Evaluating the criminal justice mental health pathway

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Thesis submitted for the degree of MD (Res)

September 2016

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Abstract

Background

High levels of mental health and substance misuse disorders within the criminal justice system (including prisons, courts and police stations) have been reported across the world. In responding to this challenge, some countries have developed liaison and diversion services. These services began in England and Wales in the 1980s, but their coverage and quality have been patchy and they have been less developed in police custody than in the courts. Studies reported in this thesis aim to evaluate one such service operating in police custody.

Methods

A multiagency group including the Local Authority, Metropolitan Police and local Mental Health Trust obtained grant funds to introduce a mental health service innovation into two police stations in South London. The service became operational in 2012, and from the outset routine service and follow-up information was collected on consecutive referrals. Data covering an 18-month period were analysed using a statistical software package. Meanwhile, the effect of an open referral system on local prison mental health in-reach team referrals was evaluated using a before-after design.

Results

The referred group (n = 1092) presented with very high levels of mental health and substance misuse morbidity, vulnerability, and suicide risk. Most had established mental health problems (66.8%) and histories of drug or alcohol use (60%) and an important number (144/888: 16.2%) presented with suicide ideation. Many (370/516: 71.7%) required onward referral to a range of

services, and although existing service linkage was protective, male gender and current drug or alcohol use predicted non-engagement.

Conclusions

It is possible for a mental health service to operate effectively in police custody, but such services require enough resources to deal with the high levels of presenting need and clinical risk. Service links appear protective and should be prioritised, but some referred groups require enhanced support to facilitate service engagement.

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Acknowledgements

I would like to thank my main supervisor, Dr Lucia Valmaggia, for her patient expert guidance and consistent encouragement over these last few years.

I would also like to thank my second supervisor, Professor Tom Craig, for the calm experience he brought to this project, as well as for suggesting that I register for an MD (Res) in the first place.

Various organisations came together in partnership to make this service and its evaluation possible, and I thank them for their persistence in seeking to deliver new services in an area that had previously been under-resourced. They include South London and Maudsley NHS Foundation Trust, Lambeth Local Authority and the Metropolitan Police Service.

The service would, however, not have existed had Guy's and St Thomas' Charity not chosen to fund our original grant application. To them, I am very grateful.

Numerous people have assisted in the development of this service over the years, whether in its design, its management, its delivery, or its evaluation. I thank them all for the important role they have played in establishing a successful and important new service. It is not possible to name everybody who was involved, but the following deserve specific thanks: Eleanor Bateman; Sue Bell; Ann Biddle; Lucas Dzakpasu; Tom Fahy; Carl Hallawell; Julie Heyward; John Martins; Chiara Samele; Karen Slade; Samir Srivastava; Roopa Ramgoolam; Sharon Ravenscroft; Kevin Valydon; Audrey Wilson.

Last, but not least, thank you to my parents (George and Katrina) and sister and brother-in-law (Moira and Joss) for their continual support and love

over the years, and to my friends and housemates for surviving the inevitable ups and downs of various paper iterations.

Chapter 1. Introduction

1.1. Background

The provision of mental health services in the lower Magistrates' Courts in England and Wales – generally referred to as *liaison and diversion* services - began in the late 1980s through the introduction of relatively small-scale unfunded local schemes (e.g. Joseph and Potter, 1993; Exworthy and Parrott, 1993; Blumenthal and Wessely, 1992). There have also been similar developments in some other countries: in the USA these services have a longer history, and they were boosted when substantial research and service developments funds were made available during the 1990s by the Clinton administration, resulting in large-scale expansion of Mental Health Courts (Steadman, Davidson & Brown, 2001); and in Australia and New Zealand Court liaison and diversion services began to take shape from the early 1990s (James, 2006). Yet although there is good experimental multi-site research evidence that the Mental Health Court model used in parts of the USA are effective in reducing re-arrests (Steadman, Redlich, Callahan, Robbins and Vesselinov, 2011), the evidence base for the impact of the liaison and diversion service model adopted in England and Wales has been less robust (Srivastava, Forrester, Davies and Nadkarni, 2013). Historically, there have been considerable variations in local liaison and diversion model delivery, with many areas having limited service coverage (Winstone and Pakes, 2010). The majority of service developments have been dependent upon the energy and interest of clinicians who have chosen to lead in this area, in the absence of a national strategy for these services, or of secure funds to ensure their

mainstream delivery (Department of Health, Home Office, 1992; Department of Health, 2009).

Meanwhile, mental health services in prisons in England and Wales have developed considerably over the last 20 years, facilitated by their phased transfer over to National Health Service (NHS) commissioning and delivery (Forrester, Singh, Slade, Exworthy and Sen, 2014; Forrester, MacLennan, Slade, Brown and Exworthy, 2014; Forrester, Exworthy, Olumoroti, Sessay, Parrott, Spencer and Whyte, 2013). During this same period, however, services provided in the criminal justice pathways leading into prisons have been less well developed, with the service offer in police custody lagging even further behind court-based provision (Srivastava et al., 2013). Over the last decade, improvements to these clinical pathways have been recommended by several key national policy reports (Ministry of Justice, 2010; Department of Health, 2009; Home Office, 2007): as a consequence, a priority has been attached to their national development not only in the lower courts, but across the whole criminal justice pathway including police custody. The broad aim has been to develop a service approach that allows for mental health case identification by screening of people of all ages at different stages in the criminal justice system, while also subsequently enabling specialist service access for those who require it (NHS England Liaison and Diversion Programme, 2014). In order to take this forward, a partnership body – *The Offender Health Collaborative* – was created in 2013, led by the National Association for the Care and Resettlement of Offenders (NACRO). Its aim was to “develop an operating model to meet the needs of all those who are in contact with the criminal justice system with mental health problems and/or a learning disability” (NACRO website, 2016).

National funds of £25 million were made available to ten sites to trial operating models (NHS England website, 2016), with a view to their subsequent evaluation and the delivery of a national operating model (NHS England Liaison and Diversion Programme, 2014). Yet despite these developments, a number of important questions have yet to be answered in this area: including whether these services can be effective in ensuring longer-term health engagement, or health improvements, or in facilitating desistance from offending behaviour (Srivastava et al., 2013).

1.2. Developing liaison and diversion services in Lambeth

The local criminal justice mental health pathway considered in this evaluation was developed within the wider national context described above. It operated across police stations in London's borough of Lambeth (Brixton and Kennington police stations), Camberwell Green Magistrates' Court (the lower court covering the London boroughs of Lambeth and Southwark) and Brixton prison (which was formerly the main remand prison for these parts of London). The local NHS provider, South London and Maudsley NHS Foundation Trust (SLaM), had provided some form of service at Camberwell Green Magistrates' Court since the 1980s, although in keeping with national service arrangements this provision had not been properly funded and it had largely depended upon the interest and dedication of local clinicians to establish and maintain its functions. It had not previously been subject to reporting arrangements, so it is not possible to comment on its effectiveness over the thirty years in which it provided some form of service. In 2008, SLaM won a contract to provide mental health services at Brixton prison, and this became a catalyst for the further development of these services across the local criminal justice pathway. A new

partnership was formed between statutory and voluntary sector partners, leading to some new service funding and improved service coverage, these developments having been described elsewhere (Forrester, 2015). Meanwhile, as court and prison developments were taking shape, a young man who suffered from paranoid schizophrenia, and had been under the care of SLaM forensic mental health services in the community, died in custody at Brixton police station in 2008. This death immediately came to national attention, and would later lead to criticisms of police conduct (Independent Police Complaints Commission, 2013) and recommendations for the improved management of people in custody who present with mental health problems (Black Mental Health, 2012). Following this death, a range of local organisations (including SLaM, the Local Authority and the Metropolitan Police) came together to support the development of a new mental health service operating in police custody in Lambeth. Grant funds were obtained from Guy's and St Thomas' Charity to implement the service and enable its evaluation, and after suitable arrangements were made the service went live in March 2012. This therefore ensured that mental health services were operational across the entire local criminal justice pathway.

1.3. Morbidity across the criminal justice pathway

High levels of morbidity across the criminal justice pathway have been well established in the literature. Although the strongest evidence has emerged from prison studies over a number of decades (Fazel and Seewald, 2012; Singleton, Gatward & Meltzer, 1998), the court literature has also confirmed these high levels (Shaw, Creed, Price, Huxley and Tomenson, 1999). Similarly, more recent research focusing on morbidity amongst police custody samples

have also reported increased levels, as well as emphasising a tendency towards complex clinical pictures and mixed morbidities that are often found to present across domains of physical and mental health, and substance misuse (Cooper, Jarrett, Forrester, Forti, Murray, Huddy, Roberts, Philip, Campbell, Byrne, McGuire, Craig & Valmaggia, 2016; Rekrut-Lapa and Lapa, 2014; McKinnon and Grubin, 2010; Payne-James, Green, Green, McLachlan, Munro & Moore, 2010). Intoxication with substances, dependence and frank withdrawal are key problems amongst this population (Clement, Gerardin, Victorri, Guigand, Wainstein & Jolliet, 2013; Dorn, Ceelen, Buster, Stirbu, Donker and Das, 2014; Coulton, Newbury-Birch, Cassidy et al., 2012; Payne-James, Wall and Bailey, 2005; Pearson, Robertson and Gibb, 2000), and have been implicated in serious incidents in police custody, including deaths (Best, Havis, Payne-James and Stark, 2006). High levels of psychiatric disorder are present within such samples, and they contribute substantially to individual vulnerability (Baksheev, Thomas and Ogloff, 2010; Baksheev, Ogloff and Thomas, 2012; Ogloff, Warren, Tye, Blaher and Thomas, 2011; Dorn, Ceelen, Buster and Das, 2013). Although these levels of morbidity are now recognised throughout the small but growing literature in this area, mental health services in police custody have persistently been under-funded and under-developed nationally (Forrester, Valmaggia, Taylor, 2016). This lack of service coverage has been compounded by existing health screening arrangements that are designed to be applied by custody sergeants, but often fail to identify serious illness and vulnerability (McKinnon and Grubin, 2013). Given these limitations, recent screening research in this area has described possible routes to improvement, including the validation of new screening tools, and

recommended that action is taken urgently (Noga, Walsh, Shaw & Senior, 2015; McKinnon & Grubin, 2010).

1.4. Suicide and suicide ideation across the criminal justice pathway

Within the context of these high levels of morbidity, and healthcare services that have only begun their development relatively recently, there were 8,129 deaths in custody (meaning deaths that took place in one of a number of establishment types, including: police stations; prisons; immigration removal centres; approved premises; secure training centres; and hospitals) in the 15 years between 2000 and 2015 (Independent Advisory Panel on Deaths in Custody, 2015). Deaths in police custody accounted for 4.4% of this number (i.e. 355 people), and over the seven years between 2007 and 2014, 101 young people between the ages 18 and 24 died in prison custody (Harris, 2015). The suicide rate in prisons is up to six times higher than in the community and other parts of the criminal justice pathway have also reported increased rates (Fazel, Gran, King and Hawton, 2011). Suicide has been identified as a particular risk on release from prison (Pratt, Piper, Appleby, Webb and Shaw, 2006), and more than a tenth (13%) of general population suicides were identified as having been managed within pathways in the criminal justice system prior to their deaths (King, Senior, Webb et al., 2015). Further work has demonstrated increased risk following court involvement (Cook and Davis, 2012) and increased suicide ideation amongst people who are being managed under the remit of community corrections (Gunter, Chibnail, Antoniak, Philibert and Hollenbeck, 2011). Recent epidemiological work has demonstrated the high prevalence of self-harming behaviour in prisons, with 139,195 such incidents having been recorded in establishments in England and Wales during the five

years from 2004; 6% of prisoners in the male estate and 24% of prisoners in the female estate (Hawton, Linsell, Adeniji, Sariaslan and Fazel, 2014). Suicide ideation, meanwhile, has a measured prevalence of almost a third amongst people in prison (Larney, Topp, Indig, O'Driscoll and Greenberg, 2012).

This increased risk of suicide associated with the various parts of the criminal justice system has been recognised formally within the national strategy to prevent suicide (Department of Health, 2012), and over the years a number of initiatives have been introduced in order to assist in managing these risks (Her Majesty's Inspectorate of Prisons, 1999; Ministry of Justice, 2013). These initiatives have broadly been aimed at increasing multi-agency cooperation, and there is some evidence for their effectiveness (Slade and Forrester, 2015), yet the literature regarding suicide, and suicide ideation, has been considerably more developed in prisons than in police custody samples. Although there are some reports of increased levels of suicide ideation in police custody, these reports have tended to sit amongst wider and more general concerns that health conditions are often missed amongst people who present there (Noga, Walsh, Shaw and Senior, 2015; Noga, Foreman, Walsh, Shaw and Senior, 2015; McKinnon and Grubin, 2013). Therefore, there has been a tendency to co-opt much of the existing prison literature and, given assumed pathways commonalities, to apply this same understanding to other parts of the criminal justice system including police custody. This has included improvements in our understanding of the link between self-harm and subsequent suicide (Hawton, Linsell, Adeniji, Sariaslan and Fazel, 2014), and in the psychological processes underpinning suicidal behaviour amongst men (Rivlin, Fazel, Marzano and Hawton, 2013) and women in prison (Marzano,

Fazel, Rivlin and Hawton, 2011). However, the paucity of available research amongst police custody samples demonstrates a need for more specific work in this area.

1.5. The wider impact of liaison and diversion services

Although there is some evidence that liaison and diversion services can introduce some benefits, including improved identification of people with mental health problems (Scott, McGilloway, Dempster, Browne and Donnelly, 2013), there is general recognition in the field that a higher standard of evidence, including experimental work, is now required (Srivastava et al., 2013). In order to move the existing evidence base forward, a new national operating model for liaison and diversion was applied to, and evaluated across, ten English trial sites with a total population coverage of over 11 million people from April 2014 (Disley, Taylor, Kruithof et al., 2016). The evaluation sought to determine whether the new model introduced benefits above locally developed models, and whether these services offered improved health and justice outcomes, before national delivery moved forward to ensure wider service coverage. There were, however, serious limitations in quantitative data collection across sites, and the project was essentially unable to answer the questions it had been set given the scale of its original ambition. However, the qualitative work that had been undertaken regarding services operating in police custody suggested strong stakeholder approval, and highlighted a number of perceived improvements, including: enhanced identification of defendants with vulnerabilities; better decision making in complex cases; and increased operational processing efficiency.

There is, however, some limited evidence of impact from literature elsewhere, while recognising that the use of multiple models can introduce varying degrees of effectiveness across sites with different remits (Lange, Rehm and Popova, 2011). These services can lead to increased numbers of local team referrals, although their wider pathways effects are less clear (Pakes and Winstone, 2009; Kingham and Corfe, 2005; James and Harlow, 2000). They may reduce court adjournments (Hean, Warr, Heaslip and Staddon, 2009) and the overall amount of time spent attending court (Kane et al., 2013). Yet although these services tend to utilise open referral systems in order to ensure their responsiveness and to maximise service access, and such models can be usefully applied in prison settings (Samele, Forrester, Urquia and Hopkin, 2016), their wider effects upon referral patterns elsewhere have not been described. However, in order to plan services effectively, such estimates are now required, not least given the largescale increase in liaison and diversion service delivery that has been proposed.

There is also some evidence of an association with improved mental health amongst both adults (Rowlands, Inch, Rodger and Soliman, 1996) and young people, with possible reductions in re-conviction rates amongst the latter (Haines, Goldson, Haycox et al., 2012). In police custody, reviews have tended to described effective operational deliver models and improved detection amongst groups presenting with high levels of morbidity, with many requiring diversion to psychiatric hospital for further assessment and treatment (McGilloway and Donnelly, 2009; Scott, McGilloway and Donnelly, 2016). An earlier pilot service operating in London reviewed 712 cases over a 31-month

period, and from this group 223 people (31.4% of the total number of referrals) were diverted to hospital care (James, 2000).

Yet despite the relatively slim evidence base for the effectiveness of these services, they now appear to have an unstoppable national momentum that was initiated by the Corston and Bradley reports (Department of Health, 2009; Corston, 2007). This same momentum led to the development of a national model (NHS England, 2014) and, following the evaluation described above, further roll-out to ensure coverage of almost half the population of England, with inevitable differences in levels of experience across sites (Disley et al., 2016).

1.6. The aims of this project

This project was initiated within one local criminal justice pathway in South London, and its development of mental health services in local police stations took place began before the national roll-out of criminal justice liaison and diversion services. Although it is not the first police liaison and diversion service to become operational in London (James, 2000), its clear setting within the context of one well-described local pathway, and the nature of its multi-agency approach, funding and resource allocation, indicates a new form of model delivery (Forrester, 2015). Such services have hardly been evaluated in England and Wales, yet we are on the cusp of a largescale national roll-out of similar services, and at a moment when there is still an opportunity to influence the final agreed model.

In order to improve understanding in this field, and mindful of the particular literature gap regarding suicide ideation across the criminal justice pathway, this evaluation had a number of key aims, as follows:

1. To describe the demographic and clinical characteristics of a cohort of consecutive referrals to a mental health service that was introduced as a grant-funded pilot to two police stations in one London borough (in Brixton and Kennington) over an 18-month period;
2. To examine the prevalence of suicide ideation amongst this same cohort;
3. To evaluate the potential effects of this new service, and the introduction of an *open referral system*, upon mental health referral work undertaken elsewhere in the local pathway, at Brixton Prison;
4. To examine the health engagement outcomes of a sub-group of consecutive referrals to the service, over a 9-month period;
5. To consider onward recommendations for research and service delivery in this field.

1.7. Continuity across themes

In keeping with the aims of the wider project, each key aim of the project was selected in order to ensure that there was a close link with the other identified themes. At the core of this project was the description of a cohort of people who had been referred to the newly introduced mental health service operating in police custody, using a consecutive sample over an 18-month period from the outset of the project. Given wider concerns about patient safety within the criminal justice pathway, and the limitations with the available literature in this area, suicide ideation was examined in further detail within the same cohort. The findings in respect of demographic and clinical features, and suicide ideation, have since been used to inform onward service design and to

inform commissioners within NHS England as they design and fund more service of this sort in other parts of London. In addition, given concerns that were raised during the planning process about potential wider pathways effects, an attempt was made to examine the impact of an open referral system. It was not possible to examine these effects within all local NHS Trust pathways, given the complexity of local services and their interconnections and the absence of a unitary database for the assembly of such information. Nonetheless, an attempt was made to examine the effect of newly introduced open referral pathways upon downstream referrals in one part of the system, at the local remand prison. Finally, the wider impact of the service, in terms of the onward health engagement of the cohort, was examined in order to assess which groups were more, or less, likely to engage. It is anticipated that this will also feed into wider service planning arrangements in the fullness of time.

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Chapter 2. Overview of methods

2.1. Settings and service operations

The mental health service (called the Criminal Justice Mental Health Service, or CJMHS) began operating in Brixton and Kennington Police Stations, the two main Police Stations in the London borough of Lambeth, from March 2012. Lambeth is one of 32 London boroughs, and the Police Stations involved in this evaluation are two of 140 Police Stations operating across the capital. Both Brixton and Kennington Police Stations provide fully operational custody suites, with front-counter assistance offered 24-hours per day, seven days per week. The borough of Lambeth itself is densely populated and ethnically and social mixed, with a population of around 310,000. It has been identified as one of the most deprived areas in London, and in England; it has a relatively young age profile and a high rate of crime, although it also has some more affluent parts (Lambeth, 2014). There were 34,912 notifiable offences in the borough during the financial year 2012/13, and they represented 4.5% of the total 771,566 notifable offences across London over the same period (Metropolitan Police website, 2016).

The CJMHS operated 12-hours per day every during day of the week, from 0800 hours to 2000 hours, and all front-line assessments were done by Community Psychiatric Nurses (CPNs). The service aimed to be as easily accessible as possible from the outset, and it therefore deliberately adopted an open referral system (Hopkin, Samele, Singh, Craig, Valmaggia and Forrester, 2016; Samele, Forrester, Urquia and Hopkin, 2016). This meant that the team assessed all referrals from whichever source they came, whether they were clinical or non-clinical in origin. In addition, in order to maximise the service's

responsiveness, and to assist the Metropolitan Police to process cases as quickly as possible in accordance with their requirements under the Police and Criminal Evidence Act 1984, the team aimed to review all referrals within a target four-hour window. Speed of service processing had been a key concern of the Metropolitan Police while the project was being designed.

In addition to nursing staff, the clinical team also had input one day per week from a Consultant Forensic Psychiatrist, who remained available throughout the week for telephone support and also attended weekly team meetings where cases were discussed. The Consultant Forensic Psychiatrist also assisted in providing some continuity with other parts of the criminal justice pathway by working in services at the nearby courts and in the local remand prison. This arrangement was intended to be in keeping with national recommendations to ensure a form of intellectual consistency across clinical pathways (Department of Health, 2009). The team also included two administrators, whose main duties involved the coordination of team information, including uploading and sharing assessment and onward referral documentation as appropriate.

In addition to Brixton and Kennington Police Stations, an audit of the effects of the introduction of wider services across the local criminal justice pathway, and of the adoption of an open referral system, was undertaken at Brixton Prison. This site was chosen because the prison, which had an operational capacity of 800 prisoners, was then the local remand prison for the London boroughs of Lambeth and Southwark. This means that it received prisoners who had been processed through these local criminal justice

pathways, having usually been considered at the local Court, Camberwell Green Magistrates' Court.

2.2. Procedures

Information was collected in the Police Stations using a document that had been designed by the clinical team and its project partners (with input from partner organisations, including both the Metropolitan Police and the Local Authority). The aim of this document was not just to collect information to enable the subsequent evaluation of the service, but also to ensure the production of a robust clinical record of the assessment as soon as possible. A standardised format was used and the document was subsequently uploaded to the Trust's electronic medical records to ensure that it could then be seen by other clinical services as appropriate. The original template (referred to as the Mental Health in Custody Assesment Tool and known by the team as *MHiC*) is included at Appendix 1, and during the initial stages of the project it utilised drop-down menus to enable its use on an electronic device. There were 14 main domains around which clinical information was collected, and information from a number of these domains (including consent, orientation, referral and response times, personal details, arrest information, mental health information, substance use information, intellectual disability, risk information, and some output information) was subsequently added to an Excel database. Information regarding current, or active, suicide ideation was collected in the risk information section after detainees were asked simply but directly whether they were experiencing such ideas at the time of the assessment. It was collected alongside information regarding previous self-harm or suicide attempts.

Although data collection was a core function of this team, its main and over-riding function was the delivery of a new clinical service, and this clinical delivery was prioritised as the team was designed and developed. The limited time available to interview detainees in Police Custody meant that the use of research diagnostic instruments had to be minimised, and the document instead focused largely on free text areas to enable a more descriptive clinical record to emerge (in keeping with the usual requirements of clinical services, and of the court team to which this information was often forwarded). Diagnoses were recorded on the basis of pre-existing clinical information when it was available, or following clinical impression when it was not. One instrument was, however, used as part of the assessment process: the Learning Disability Screening Questionnaire, for which a team and service license was purchased (McKenzie, Michie, Murray and Hales, 2012).

All referrals were prioritised in terms of their clinical need, with those presenting with the most acute self-harm or suicide risk, or with what appeared to be the most acute mental health problems, being seen earlier. Assessors were assisted in their examinations by information contained in the Police Custody records and the local Trust electronic record system, to which access had been made available.

After assessments were completed by the nursing team, further clinical referral details were recorded for those who had required onward referral to other services. Criminal justice outcomes were also meant to be recorded, although in the final database this information was often missing, reflecting the difficulty the clinical team had in accessing it within the context of a busy clinical service that was not fully operational across a full 24 hour period. After referrals

had been sent, CPNs liaised with the receiving services to assist with the process of onward health engagement, in keeping with key liaison and diversion aims (Department of Health, 2009). Following initial liaison, this further liaison work took place at a number of defined stages: week two, week four; month three; and month six. Health engagement outcomes were also recorded during this liaison process in order to examine one of the main aims of the service. This health engagement information was collected using a simple yes/no format to identify whether the individual had attended an appointment with the recommended service (yes) or had not (no).

2.3. Analysis of data

All data were analysed using statistical software (SPSS, v22), after being transferred over from an original Excel file. This process enabled weekly data checks to take place as entry was proceeding, in order to reduce any potential errors and make sure that missing data were highlighted. Once the data had been fully prepared, analyses were undertaken for each aspect of the project's evaluation as described below.

The examination of demographics and clinical characteristics of 1092 consecutive police custody mental health referrals was initially analysed using descriptive statistics. After this, a number of Chi-square tests were undertaken and all results were presented in various tables. The examination of suicide ideation amongst people referred for mental health assessment in police custody also involved a number of Chi-square tests. Two groups were compared in this analysis - people who answered *yes* to having suicide ideation, and people who answered *no* to having suicide ideation - across a series of demographic and clinical variables.

The audit of referrals to the prison mental health in-reach team across two different time periods following the introduction of an open referral was also examined using descriptive statistics. These enabled the description of various clinical and demographic features. The further use of Fischer's exact tests allowed differences between referrals at both points to be examined. Missing variables, identified in under 5% of the available information, were removed from the analysis. A multivariate logistic regression analysis was also undertaken in order to determine variables associated with being accepted for the caseload of the prison's mental health in-reach team.

The examination of health engagement outcomes used five variables as outcomes to check whether any characteristics significantly increased or decreased the chances of taking up a service at (i) week two (ii) week four (iii) month three (iv) month six and (v) taking up a service at any of the four time points. Once a final list of variables was identified for each time point through preliminary models, a logistic regression model was created that included multiple predictors for each time point. Only variables that had enough data in each response option were included in the models.

2.4. Ethical and governance considerations

The operations of the CJMHS clinical project were designed by a multi-agency group that included representatives of the three main involved agencies (SLaM, Lambeth Local Authority and the Metropolitan Police). Once the service became operational, a governance oversight group met quarterly to oversee its work, chaired by a Local Authority Service Director. This governance group contained representatives of all involved agencies, and it also included representation from London Probation Service, local Councillors and a user

group. Within SLaM, ground-level governance arrangements sat within offender health, which was then one of five service lines within the Behavioural and Developmental Clinical Academic Group (itself one of seven Trust-wide divisions). This local group met monthly and it reported into the Clinical Academic Group's monthly Senior Management Team meetings, from which senior clinical and managerial representatives were delegated to attend the project's main governance oversight group.

National and local guidelines were followed to assist in determining the nature of the project (Health Research Authority website, 2016; King's College London website, 2016; National Patient Safety Agency, 2007). In accordance with these guidelines, the CJMHS examination was approved as service evaluation project by the relevant local Trust governance group (formerly called the Clinical Effectiveness Group, subsequently renamed the Research Outcomes and Service Evaluation group). This is because the project sought to measure the service, rather than answer any specific hypotheses, and because it involved a standard intervention that was offered to all patients as part of the work of the service (i.e. initial assessment, followed by onward liaison with and referral to other services when required). It did not attempt to allocate people to intervention groups or introduce any form of randomisation, and data that were subsequently analysed had been collected as part of the service standard specification. The examination of prison mental health referrals following the introduction of an open referral system was also approved as an evaluation by the Clinical Effectiveness Group. Permission to publish the findings was granted by the governance oversight group, the local Trust governance group, and, in the case of the prison evaluation, the prison Governor.

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Chapter 3. Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals

3.1. Citation

Forrester, A., Samele, C., Slade, K., Craig, T., & Valmaggia, L. (in press). Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals. The Journal of Forensic Psychiatry and Psychology (accepted for publication on 30 June 2016).

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3.3. Acknowledgements

Thank you to Guy's and St Thomas' Charity, which provided funding for this service and its evaluation. Thank you also to Carl Hallawell, team leader, to current and former team members who assisted with aspects of template design and data collection, and to our partner organisations in this project.

3.4. Abstract

The 43 police forces in England and Wales have made over 13 million arrests in the last decade. Yet despite this high volume criminal justice system activity, and evidence of substantial health morbidity across the criminal justice pathway, mental health services in police custody have so far only been developed in patches, and the literature in this area is limited. Referrals (n=1092) to a pilot mental health service operating across two police stations in a London borough were examined over an 18-month period in 2012/13. The referred group had high levels of mental health and substance misuse problems (including acute mental illness, intoxication and withdrawal), self-harm, suicide risk and vulnerability, with some important gender differences. Although this work has limitations, the findings are broadly consistent with the small existing literature and they confirm the need for services that are sufficiently resourced to meet the presenting needs.

3.5. Introduction

England and Wales have 43 regional police forces, each of which covers a particular territorial area and is complemented by three national special police forces (the British Transport Police, the Civil Nuclear Constabulary and the Ministry of Defence Police). Over the last decade these forces have made thirteen million arrests, although overall arrest numbers have reduced considerably from almost 1.5 million in 2007 to 950,000 in 2015 (Home Office, 2015). The vast majority of arrestees are male (84%), and around a third of the overall total are for violent crimes against the person, with around a fifth being for theft or handling stolen goods (Home Office, 2015). Although this number of arrests is high, reported crime is even higher, with 4.3 million offences recorded

during the year ending September 2015, representing a 6% increase on the previous year (Office for National Statistics, 2016).

Meanwhile, there is considerable evidence that criminal justice system populations present with substantial health morbidities, this excessive morbidity having been demonstrated amongst both prison and court groups (Fazel & Seewald, 2012; Shaw, Creed, Price, Huxley & Tomenson, 1999). These groups initially enter the criminal justice system by being arrested and processed through police custody, and therefore it is not surprising that a more recent and developing literature that has focused specifically on detainees in police custody has also found high levels of morbidity across a range of health measures. Complexity and mixed pathology across domains have emerged as key themes (Rekrut-Lapa & Lapa, 2014; McKinnon & Grubin, 2010; Payne-James, Green, Green, McLachlan, Munro & Moore, 2010). High levels of substance use and dependence have been identified, with a wide range of substances (both legal and illegal) being consumed, and serious problems arising in police stations as a consequence of both substance intoxication and withdrawal (Clement, Gerardin, Victorri, Guigand, Wainstein & Jolliet, 2013; Dorn, Ceelen, Buster, Stirbu, Donker & Das, 2014; Coulton, Newbury-Birch, Cassidy, Dale, Deluca, Gilvarry, Godfrey, Heather, Kaner & Oyefeso, 2012; Payne-James, Wall & Bailey, 2005; Pearson, Robertson & Gibb, 2000). Substance use also plays an important role in deaths and near miss incidents in police custody suites (Best, Havis, Payne-James & Stark, 2006). Mental health problems are also over-represented amongst police detainees, with studies describing a highly vulnerable group (Baksheev, Thomas & Ogloff, 2012) from which a quarter have a history of psychiatric hospital admission, three-quarters

meet the criteria for a diagnosis of mental disorder, and one-third present with mental health and substance misuse co-morbidities (Baksheev, Thomas & Ogloff, 2010). More than half of one sample of 614 detainees (55%) had a history of contact with publicly provided mental health services, and this same group exhibited more psychiatric symptoms while they were in police custody (Ogloff, Warren, Tye, Blaher & Thomas, 2011). Using the Brief Jail Mental Health Screen (Steadman, Redlich, Callahan, Robbins & Vesselinov, 2009) 40% of a randomly selected sample of detainees in police custody in Amsterdam scored positive, requiring further evaluation (Dorn, Ceelen, Buster & Das, 2013) and a further 35% having additional social problems (Buster, Dorn, Ceelen, Das, 2014). However, despite these high levels of morbidity, assessment and referral services in police custody in England and Wales are presently under-developed when compared with other parts of the criminal justice system, with custody officers holding the main responsibility for identifying health needs using a standardised instrument. This tool is applied to all detained individuals, and although it contains questions covering mental health, physical health, substance misuse and withdrawal, and self-harm risks, its effectiveness has been called into question by research (Noga, Walsh, Shaw & Senior, 2015). These existing processes are known to miss many cases of mental illness and alcohol withdrawal, as well as missing almost half of those who require the support of an appropriate adult because of underlying vulnerability or mental capacity issues (McKinnon, Srivastava, Kaler & Grubin, 2013). Given these limitations, there have been clear calls for the implementation of better standardised tools to improve the identification of

mental health problems in police custody (Baksheev, Thomas & Ogloff, 2010; McKinnon & Grubin, 2012).

At the same time as these morbidities amongst police custody detainees have increasingly been uncovered by research, there has been a movement within England and Wales to develop criminal justice liaison and diversion services in courts and police stations (Srivastava et al., 2013). Despite their evidential limitations (Scott et al., 2013), there is presently a national intention to introduce and improve services for all people who present with mental health problems in the criminal justice systems using an all-age model which is focused on identifying cases through screening, with subsequent specialist assessment when it is required (NHSE, 2014a). Although these liaison and diversion services existed in England and Wales before the policy landscape shifted, albeit largely based in the lower (Magistrates') courts (James, 2006), the relatively recent priority that has been attached to their development has arisen from influential national policy reviews and subsequent Government responses (Bradley, 2009; Corston, 2007; Ministry of Justice, 2010). In order to move this new provision forward, ten trial sites received a financial investment of £25 million from 2014 (NHSE website, 2016), with the aim that they would be evaluated and that a standardised service specification would subsequently be introduced nationally (NHSE, 2014b).

This project was developed within that wider policy landscape, and it introduced one pilot mental health service to meet the health needs of detainees in police custody in one London borough. It followed an earlier piece of work in which the unmet needs of this group had been locally identified using

a needs-based evaluation (Rapley et al., 2011), and the project was introduced as a grant-funded service response.

The evaluation of this new clinical service aimed to describe the demographic and clinical characteristics of the first consecutive cohort of referrals over an 18-month period, as well as examining gender differences amongst the referred group given evidence of the particular health problems faced by women in the criminal justice system (Plugge et al., 2006; Scott et al., 2009) and an earlier national policy review in which a number of specific needs were posited (Corston, 2007).

3.6. Method

Setting and service operations

This pilot criminal justice mental health service (CJMHS) operated in two police stations in one south London borough (representing two of the 140 police stations operated by the Metropolitan Police Service across London). The service operated seven days per week between the hours of 8am and 8pm. It used an 'open referral system' approach (meaning that it was available to take referrals from a wide range of individuals or agencies, including non-clinical sources such as police officers and self-referrals), and it accepted referrals in a number of forms in order to facilitate prompt service access (e.g. written, email, or telephone referrals). Initial screening was done on reception by desk sergeants using a standardised process that has been described elsewhere (Noga, Walsh, Shaw & Senior, 2015). Following referral, mental health assessments were undertaken by nursing staff (known as Community Psychiatric Nurses, or CPNs) who were able to access telephone advice from a Consultant Forensic Psychiatrist if it was required, although in reality psychiatric

support was only required in cases where diversion to psychiatric hospital was considered. The team operated a target of four hours to assessment, and all referrals were seen the same day given requirements of code C of the Police and Criminal Evidence Act 1984 (PACE), which sets out the requirements for detaining, treating and questioning suspects in custody. Referrals were clinically reviewed in a private space and efforts were made to ensure that the assessment process was not interrupted (although there were some interruptions, for example to request attendance for police interview). The clinical team then discussed these referrals at the subsequent weekly team meeting that was attended by medical, nursing and administration staff.

Participants

A total of 1092 detainees were assessed between 06.03.2012 and 31.08.2013, representing 15% of the total arrest volume during this period. From this group, 869 (79.6%) were male (mean age = 36.6, sd = 11.1), 218 (20.4%) were female (mean age 36.7, sd = 11.7), with 4 (0.3%) identified as transgender or transsexual.

Procedure

After receiving referrals, CPNs ranked them in order of their urgency before proceeding to undertake a clinical assessment, prioritising people who had been identified as presenting a risk of self-harm and/or suicide, or who were thought to be acutely mentally unwell (while those who were intoxicated with or withdrawing from alcohol were returned to primary care services for further management). While undertaking the assessment, CPNs had access to NHS clinical information from the local mental health Trust records, and to police records including criminal justice information. The details of this

assessment were then recorded on a template that was designed specifically for this project and subsequently uploaded to the electronic clinical record of the providing Mental Health Trust. This document had three main functions: its main aim was to ensure that a high quality standardised clinical record was produced as quickly as possible, given the operational limitations that often arise when attempting to undertaking clinical assessments of people in police custody (McKinnon & Grubin, 2012); its second aim was to ensure a mobile clinical record that could easily be uploaded to existing electronic record systems; and its third aim was to collect information to record the activities and outcomes of the service to enable its evaluation. The template design ensured that information was collected across a number of domains (personal details; referral and response times; arrest information; consent; consciousness and orientation; demographic information; mental health; diagnosis; substance misuse; intellectual disability; self-harm and suicidality). Although personal and demographic information was mainly obtained by self-report, arrest and clinical information was obtained through a mixture of self-report and available records.

Primary and secondary diagnoses were recorded in accordance with information from available clinical records when they were available, and when they were not available it was recorded on the basis of clinical impression. As part of the assessment process, however, a rating scale was used to screen for the presence of intellectual disability in cases where vulnerability concerns were reported, or after individuals had self-reported an intellectual disability (the Learning Disability Screening Questionnaire: McKenzie, Michie, Murray & Hales, 2012). Other validated screening tools were not, however, used because the main prioirity of the service was to provide timely clinical triage within the

requirements of PACE, rather than to undertake a research-based examination of the prevalence of mental disorder. The wider template also included free-text boxes which were available for the assessor to record information regarding mental state, clinical impression, and their assessment of any risks presented (including risks to self, or to others), largely for the purposes of clinical assessment and deriving an opinion.

Analyses

Anonymised data were entered into an Excel database on a rolling weekly basis and were checked for errors and missing data. Once prepared, data were then transferred to a statistical software package to facilitate the project's overall evaluation. This software package (SPSS, v22) was then used to provide descriptive statistics. Following analysis using a series of Chi-square tests, data tables were prepared to enable the presentation of results.

In addition, a comparison was undertaken regarding arrest offences reported in this evaluation against the official offence rate for 32,923 offences reported within the same London borough during 2013-14 (Metropolitan Police, 2014). As prevalence rates were similar between males and females, the full sample was compared with official rates for the following groups: violent offences (22.3%), sexual offences (1.7%), theft (60.5%) and fraud (0.015%).

Ethics and governance

The clinical project was overseen by a governance board that included representation from the local National Health Service (NHS) mental health Trust that provided clinical staff to the project (South London and Maudsley NHS Foundation Trust), the local authority (Lambeth Council), the Metropolitan

Police Service and London Probation Service. The work received local Trust governance approval as a service evaluation project.

3.7. Results

Demographic variables

Almost three-quarters (814; 74%) provided consent to be interviewed (656 (76%) of men and 158 (73%) of women). The vast majority were registered with a General Practitioner for primary care services (86%) and spoke English as their first language (78%). A range of ethnicities were represented in the sample, mainly White (49%) and Black (36%) groups. A large number were single (65%), with much smaller numbers in cohabiting relationships (6%), married or in civil partnerships (5%), separated (3%), or declining to disclose (18%). The largest number lived in rented social housing (43%), with others declining to describe their housing status (22%), living with family or friends (13%), hostel accommodation (13%), or being street homeless (8%). A minority of the sample were in work (14%) and almost half (48%) were described as being in receipt of State benefits. As regards their educational status, the largest group had no qualifications (27%). As outlined in Table 1, there were no significant gender difference on any demographic measures, except that women were significantly more likely to have children.

Table 1:

Frequency and percentage of demographic characteristics by men and women

QUESTION		Male n=x (%)	Female n=x(%)	Total n=x(%)	Pears-on $X^{2(1)}$	p	95% CI difference
Has a GP		670 (85)	174 (87)	844 (86)	3.129	.209	-9 – 3.5
English first language		667 (77)	179 (82)	846 (78)	3.009	.083	-11.5 – .7
Ethnicity	White (British/Irish/Other)	416 (48)	110 (50)	526 (49)			
	Black (Caribbean/African/ Other)	322 (37)	70 (32)	392 (36)			
	Asian (Indian/Pakistani/ Bangladeshi/Other)	27 (3)	8 (4)	35 (3)			
	Mixed background	80 (9)	25 (12)	105 (10)			
	Any other ethnic background	23 (3)	5 (2)	28 (3)			
Marital status	Single	568 (65)	140 (64)	708 (65)			
	Cohabiting	48 (6)	17 (8)	65 (6)			
	Married/civil partnership	44 (5)	8 (4)	52 (5)			
	Divorced/partnership dissolved	25 (3)	6 (3)	31 (3)			
	Not dissolved	153 (17)	41 (19)	194 (18)			
	Separated	23 (3)	6 (3)	29 (3)			
	Widowed/survived partner	7 (1)	0 (0)	7 (1)	15.693	**.000***	**-18.6 - - 3.6**
Has Children		266 (31)	91 (42)	357 (33)			
Current housing	Homeowner	15 (2)	3 (2)	18 (2)			
	Social rented	329 (41)	96 (48)	425 (43)			
	Family/friends	108 (14)	17 (8)	125 (13)			
	Hostel	102 (13)	23 (11)	125 (13)			
	Squatting	4 (1)	0 (0)	4 (0)			
	Street homeless	65 (8)	12 (6)	77 (8)			
	Declined to say	173 (22)	50 (25)	223 (22)			
Currently working		132 (15)	23 (11)	155 (14)	3.504	.320	-9 – 3.5
Receives benefit		402 (47)	112 (52)	514 (48)	3.73	.292	-12.8 – 2.5
Highest education	Degree or above	41 (5)	13 (6)	54 (5)			
	A-level or equivalent	53 (6)	14 (7)	67 (6)			
	GCSE or equivalent	136 (16)	28 (28)	164 (15)			
	Below GCSE level	82 (10)	21 (10)	103 (10)			
	Other qualification	20 (2)	5 (2)	25 (2)			
	No qualifications	242 (28)	48 (22)	290 (27)			
	Refused to say	216 (25)	70 (32)	286 (27)			
	Not known	74 (9)	18 (8)	92 (9)			

Criminal justice process and offences

The majority of detainees had initially been reviewed using the standardised police reception screen (93%), and a minority of this number had subsequently been reviewed by a primary care nurse (32%), an arrest referral worker (14%), or a Forensic Medical Examiner (19%). The majority (81%) had already been found fit for police interview after being reviewed by a custody officer and, in some cases where doubts arose regarding their fitness for interview a healthcare practitioner had also been consulted. A wide range of alleged offences were represented in the sample (including violent, sexual, acquisitive, drug-related and other alleged offences). A minority (17%) were on bail at the point of arrest, or had outstanding warrants (10%). Most of the referred group had a history of convictions (81%), of which the majority were for violent offences (52%). As outlined in Table 2, there were no significant gender differences on the majority of measures, although men were more likely than women to have a criminal record and to have prior convictions for violent offences.

When the sample was compared with official rates for offences in the same London borough, violent sexual and fraud offences were found to be over-represented (violence $Chi^2 = 42,443$, $p < 0.001$; sexual offences $Chi^2 = 1236.47$, $p < 0.001$; fraud $Chi^2 = 1886.5$, $p < 0.001$) while theft offences were under-represented ($Chi^2 = 1385.69$, $p < 0.001$).

Table 2:

Screening processes, arrest offence and criminal history (frequency and percentage) by men and women

QUESTION		Male n = x (%)	Female n = x (%)	Total n = x (%)	Pears-on $X^{2(1)}$	p	95% CI difference
Location of arrest	Police station 1	355 (41)	94 (44)	559 (42)	2.142	.343	-9.9 – 5.3
	Police station 2	511 (59)	122 (56)	633 (58)			
Initial police reception screen		788 (93)	201 (95)	989 (93)	1.891	.169	-5.8 – 2.8
Primary care nurse review		265 (31)	75 (34)	340 (32)	0.923	.337	-11.2 – 3.4
Arrest referral worker review		120 (140)	28 (13)	148 (14)	0.212	.646	-4.3 – 6.2
Forensic Medical Practitioner review		161 (19)	41 (19)	202 (19)	0.003	.960	-6.4 – 5.8
Fit for police interview		664 (81)	164 (80)	828 (81)	0.171	.679	-5.5 – 7.9
Arrest Offence	Major Violence (Grievous Bodily Harm, Wounding, Manslaughter, Murder)	166 (19.1)	46 (21.1)	212 (19.5)	.433	.284	-8.3 – 4.3
	Minor Violence (Common Assault, Actual Bodily Harm, Assault on Officer)	94 (10.8)	28 (12.8)	122 (11.2)	.709	.232	-7.2 – 3.1
	Sexual Offence (Contact)	75 (8.6)	17 (7.8)	92 (8.5)	.159	.404	-3.5 – 5.2
	Sexual Offence (non-contact)	99 (11.4)	32 (14.7)	131 (12.1)	1.76	.114	-8.7 – 2.1
	Theft (Burglary, Theft and Robbery)	10 (1.2)	2 (0.9)	12 (1.1)	.088	.555	-1.4 – 1.9
	Drug offences	207 (23.8)	48 (22)	255 (23.5)	.736	.318	-4.7 – 8.3
	Arson	53 (6.1)	10 (4.6)	63 (5.8)	.736	.248	-1.9 – 5
	Fraud	73 (8.4)	24 (11)	97 (8.9)	1.447	.143	-7.4 – 2.2
	Threats	65 (7.5)	16 (7.3)	81 (7.5)	.006	.537	-3.9 – 4.2
Criminal record		698 (83)	155 (74)	853 (81)	10.033	**.002***	**2.3 – 16**
Convictions for violence		454 (55)	82 (40)	536 (52)	14.335	**.000***	**7.1 – 22.2**
On bail when arrested		145 (18)	30 (140	175 (17)	1.764	.184	-2.6 – 8.4
Outstanding warrants		87 (11)	14 (7)	101 (10)	3.183	.074	-.5 – 7.7

* Significant at p<.05 level

Clinical variables

The vast majority presented in clear consciousness (93%), although a small but important number presented with reduced consciousness (7%), with substance intoxication playing an important role (6%). Additionally, there was evidence of current drug or alcohol withdrawal in a small number (6%). All such cases were referred back to primary care medical services for further management. Most referrals were already registered on the local mental health information system (68%), or were actively engaged with services (64%), with many having a history of admission to in-patient mental health services (61%) or being engaged under the care of a community mental health team (CMHT: 48%). The majority reported a history of alcohol or drug use (60%), with men being significantly more likely to have such a history (see Table 3). A substantial number used substances in the 24-hours prior to their arrest (42%), and although detainees described using a range of substances, alcohol was the main substance identified (45%). Despite these high levels of alcohol and substance use, less than a fifth (16%) were known to substance misuse services. A small but important number (6%) were identified as having an intellectual disability, while a larger number (35%) reported previous suicide attempts, or a history of self-harm (33%). As outlined in Table 3, women were significantly more likely than men to present with a history of self-harm or of suicide attempts. Over a tenth of respondents (13%) reported current suicidal ideas, with almost a fifth being clinically assessed as presenting a suicide risk (19%). Women were significantly more likely to be in this suicide risk group. Of this group, almost a tenth had already harmed themselves (9%). From the

overall sample, just under a tenth required diversion to psychiatric hospital (8%), with men being significantly more likely to require hospitalisation.

Table 3:

Frequency and percentage of substance use and clinical characteristics by men and women

QUESTION		Male n=x (%)	Female n= (%)	Total n= (%)	Pears-on X^2	p	95% CI difference
Level of consciousness	Clear consciousness	804 (93)	203 (93)	1007(93)			
	Reduced consciousness	61 (7)	15 (7)	76 (7)			
Substance intoxication		53 (6)	12 (6)	65 (6)	0.12	.730	-3.1 – 4.3
Evidence current alcohol/ drug withdrawal		48 (6)	15 (7)	63 (6)	0.563	.453	-2.6 – 5.3
Registered on local mental health system		584 (67)	157 (72)	741 (68)	2.06	.151	-11 – 2.2
Actively known to services		548 (63)	152 (70)	700 (64)	4.283	.117	-11.8 – 2.2
History of in-patient admission		350 (62)	91 (58)	441 (61)	3.603	.308	-9.1 – 6.1
Under the care of a CMHT		276 (49)	71 (45)	347 (48)	1.505	.471	-8 – 6.4
Use of alcohol or drugs		543 (63)	109 (50)	652 (60)	15.14	**.002***	**4.8 – 20.1**
Used substances in 24-hours before arrest		370 (43)	80 (37)	450 (42)	3.248	.197	-1.6- 13.4
Take medication		372 (43)	100 (46)	472 (43)	4.194	.241	-10.7 – 4.6
Taking medication as prescribed		258 (79)	69 (21)	327 (50)	2.959	.398	-9.1 – 5.2
Substances used	Acid or LSD	10 (1)	0 (0)	10 (1)			
	Alcohol	407 (47)	82 (38)	489 (45)			
	Amphetamines	14 (2)	6 (3)	20 (2)			
	Cannabis	87 (10)	16 (7)	103 (10)			
	Cocaine	15 (2)	3 (1)	18 (2)			
	Crack	14 (2)	4 (2)	18 (2)			
	Heroin	6 (1)	1 (1)	7 (1)			
	Solvents	1 (0)	0 (0)	1 (0)			
Frequency of substance use	Once a month or less	45 (11)	7 (9)	52 (11)	11.763	**.038***	**-1.1 – 5**
	1-2 times weekly	99 (24)	21 (27)	120 (25)			
	3-4 times weekly	75 (19)	15 (19)	90 (19)			
	>4 times week	30 (7)	12 (15)	42 (9)			
	Daily	156 (39)	23 (29)	179 (37)			
Known to substance misuse services		143 (17)	29 (13)	172 (16)	1.595	.660	-2.7 – 8.6
Learning disability		48 (6)	13 (6)	61 (6)	4.058	.398	-4.2 – 3.3
History of self harm		261 (30)	93 (43)	354 (33)	13.723	**.001***	**-20.1 - - 5.1**
History of suicide attempts		283 (33)	90 (41)	373 (35)	7.559	**.023***	**-16.2 - -1.2**
Current suicidal ideas		107 (12)	35 (16)	142 (13)	3.061	.216	-9.4 – 1.9
Suicide risk		148 (17)	52 (24)	200 (19)	12.482	**.002***	**-13.3 - - .3**
Had already harmed themselves		79 (9)	15 (7)	94 (9)	1.574	.455	-1.9 – 6.4
Diverted to hospital		80 (9)	9 (4)	89 (8)	6.815	**.009***	**1.5 – 8.6**

* Significant at p<.05 level;

Most of the sample (66.8%) had established mental health problems, of which almost a tenth (8.3%) were acutely unwell, over a further quarter (26.8%) presented with some symptoms, almost a third (29.8%) were stable and there was uncertainty regarding a further fifth (19.9%). Large numbers presented with primary problems in respect of drugs or alcohol (21.2%), psychotic illnesses such as schizophrenia (20.1%), affective disorders such as depression (16.6%) or bipolar affective disorder (8%), or were reported as not applicable/having no mental disorder (15%). Smaller numbers were identified as presenting with primary personality disorders (8.2%), anxiety disorders including post-traumatic stress disorder (5.4%), with smaller numbers presenting with primary neurodevelopmental disorders such as intellectual disability or attention deficit hyperactivity disorder.

Table 4:

Frequency and percentage of type of mental health problem and symptoms by men and women

Question		Men (%)	Women (%)	*P*	95% CI difference
Established mental health problem		584 (67.2)	141(64.7)	.713	-4.8 – 9.8
Mental health status	Acutely unwell	82 (9.4)	9 (4.1)	.125	1.7 – 8.8
	Some symptoms	227 (26.1)	66 (30.3)		
	Mental health issues but stable	259 (29.8)	62 (28.4)		
	Uncertain	173 (19.9)	46 (21.1)		

* Significant at p<.05 level; ** significant at p<.01 level

Primary Diagnosis	Frequency	Male	Female	Percentage
Mental/behavioural disorder drugs/alcohol	232	191	41	21.2
Schizophrenia/psychosis	220	190	30	20.1
Depression	181	138	43	16.6
N/A or none	164	126	37	15
Personality disorder	90	57	31	8.2
Bipolar affective disorder	87	67	19	8
Acute stress reaction/anxiety/OCD/PTSD	59	48	10	5.4
ADHD/conduct disorder	26	21	5	2.4
Other/unspecified mental disorder	17	16	1	1.5
Autism	10	9	1	0.9
Brain damage/traumatic epilepsy	4	4	0	0.4
Intellectual disability	2	2	0	0.2
Total	1092	869	218	100

3.8. Discussion

Despite the limitations of the existing literature regarding criminal justice liaison and diversion services (Scott, McGilloway, Dempster, Browne & Donnelly, 2013), experimental research methods have demonstrated the effectiveness of a mental health court model in the USA (Steadman, Redlich, Callahan, Robbins & Vesselinov, 2011). Evidence for the liaison and diversion model that is preferred in England and Wales (a model that does not explicitly include aspects of therapeutic jurisprudence) is, however, more limited (Scott, McGilloway, Dempster, Browne & Donnelly, 2013; Srivastava, Forrester, Davies & Nadkarni, 2013). Similarly, although diversion at an early point in the criminal justice pathway, from police custody, has been seen as necessary and achievable (Birmingham, 2001; James, 2010), the literature presently contains few descriptions of such services. Where services have been reviewed, they have described an effective service delivery model, with appropriate identification of mental health problems, and a highly morbid referral group from which many required admission to psychiatric hospital (James 2000; McGilloway & Donnelly, 2009; Scott, McGilloway & Donnelly, 2015). Similarly, this project has demonstrated that a mental health service delivery model can be applied within police custody, and that it can be effective in assessing people who present there with mental health problems, identifying a highly morbid group. This particular service started to receive a high number of referrals from its outset (taking 1092 referrals over a 17 month period, approximately 64 referrals per month), suggesting that it quickly filled an existing service gap. A relatively high number of referrals were registered with a General Practitioner (85%), this number being higher than found in other studies (James, 2000), but

this is at least partially explained by the fact that many (68%) were already known to local services. Broadly in keeping with other literature in the field, a range of ethnicities were represented, the majority were single, a range of accommodation types were described (with over a third living in temporary or hostel accommodation, or being homeless), and almost half were in receipt of State benefits.

The team operated an open referral process, but the majority of referrals had initially been reviewed by the police reception screen, with a number seeing other services (e.g. primary care) before being referred onto the mental health team. Although the use of a clinical screen at point of reception would have been preferred, this was not in keeping with nationally agreed police processes (Noga, Walsh, Shaw & Senior, 2015) and it could not be introduced for that reason. Although the majority had been declared fit to be interviewed, an important number (7%) presented with reduced consciousness, often because they were intoxicated with alcohol or substances (6%), and a group (6%) presented with features of withdrawal. These findings, and the high levels of substance misuse and intellectual disability which have been described in the sample, are also consistent with the existing literature (e.g. Baksheev, Thomas & Ogloff, 2010; McKinnon, Srivastava, Kaler & Grubin, 2013; Young, Goodwin, Sedgwick & Gudjonsson, 2013), and they confirm a need for rapid access to medical services to review comorbidities, and to prevent serious deterioration, or mortality, arising from alcohol withdrawal in particular (Mirijello, D'Angelo, Ferrulli, Vassallo, Antonelli, Caputo, Leggio, Gasbarrini & Addolorato, 2015). In other jurisdictions where people who are severely intoxicated with alcohol are no longer held in police custody, there has been a substantial (75%) reduction

in deaths (Aasebo, Orskaug & Erikssen, 2016); there is an argument for a similarly vigilant approach in England and Wales.

A high number of referrals were registered on local mental health databases (68%), known to services (64%), had previously been admitted (61%) or were actively under the care of a community team (48%). Although these high numbers are in keeping with earlier literature that has demonstrated high levels of psychiatric morbidity in police custody (e.g. Baksheev, Ogloff & Thomas, 2012), they do indicate that these particular police stations were assuming some of the functions that are meant to be provided by community mental health services, and operating, at least in part, as mental health assessment and triage centres. The fact that almost a tenth of the group were acutely unwell or required admission to hospital further supports this argument, and raises questions about the nature of existing community services, and their ability to contain and manage some individuals with mental health problems. The major primary diagnostic categories identified (mental disorder related to drug and alcohol use, psychotic illnesses such as schizophrenia and affective disorders such as depression and bipolar disorder) were in keeping with the wider literature. The referred group was vulnerable, and the finding that that a small but important number (6%) screened positive for intellectual disability was also in keeping with existing literature showing a similar proportion (6.7%) in a screened sample (Young, Goodwin, Sedgwick & Gudjonsson, 2013). This finding supports the need for coordinated safeguarding procedures in police custody, including the use of appropriate adults (Medford, Gudjonsson & Pearse, 2003).

The gender differences found in this evaluation were also broadly in keeping with the existing literature: the women were more likely to have children, and less likely to have a criminal record, or to have prior convictions for violent offences (Corston, 2007). Women were also more likely to present with a history of self-harm, in keeping with the prison literature (Hawton, Linsell, Adeniji, Sariaslan & Fazel, , 2014), but in this sample they were less likely to require hospital diversion. The fact that over a third of the overall sample had a history of suicide attempts, that over a tenth reported active suicidal ideas, and that almost a fifth were assessed as presenting a suicide risk is clinically alarming, and it indicates a need for services that are able to identify and manage the resulting risks (including the provision of observations when they are needed). The finding that almost a tenth of referrals had already harmed themselves, given the known link between self-harming behaviour and subsequent suicide (Hawton, Linsell, Adeniji, Sariaslan & Fazel, 2014), suggests a need for a coordinated response to self-harming behaviour within police custody that is similar in its approach to the multi-agency response that was introduced by the prison service to address safety issues in the prison estate (Ministry of Justice, 2013). Population-based work has confirmed that criminal justice populations are at high risk of suicide, with over a tenth being in the criminal justice system in the period before their death (King, Senior, Webb, Millar, Piper, Pearsall, Humber, Appleby & Shaw, 2015), and to some extent it should therefore not be surprising to encounter such high levels of clinical risk in police custody.

This work was undertaken as an evaluation and it therefore presented a number of limitations. Evaluations, by their nature, do not answer questions

under experimental research conditions, but instead provide information regarding specific programmes, are often undertaken within conditions that are subject to local changes, and are generally focused on key stakeholder questions (Twycross & Shorten, 2014). The service reviewed a referred sample, rather than screening the whole group, and no form of randomisation or case selection was used because there was an operational priority regarding service delivery. Although it would have been preferable to select referrals using an initial validated clinical screen, given evidence that the police screen which is currently used can miss morbidity (McKinnon & Grubin, 2012), it was not possible to do so because the police service uses a nationally agreed standardised approach (Noga, Walsh, Shaw & Senior, 2015). Although there were good response rates, we did not record reasons for non-response (although a variety of factors were applicable, including reduced consciousness, intoxication, language barriers and clear refusals). Further, although we intended to collect primary and secondary diagnoses, the latter were not reliably recorded and therefore could not be analysed. The evaluation took place in only two police stations in one London borough, and was therefore not multi-site in its nature. Further, some of those who were approached did not fully engage in assessment, resulting in inevitable information gaps with some under-reporting. Nonetheless, within the terms of the evaluation we were able to collect at least some information on all 1092 referrals to the service, ensuring as full a dataset as possible.

Yet despite these limitations, the main strength of this work is that it does provide a real-time evaluation of a pilot service at a time when services such as this are being considered for national development, and the findings in respect

of this relatively large and consecutive sample are likely to be useful in informing onward service design. It demonstrates that a mental health service can operate effectively in police custody and deal with a high-volume referred sample that presents with some important gender differences. It also indicates that such services should expect to encounter, and be sufficiently resourced to manage, high levels of complexity and co-morbidity, with mental health and substance misuse problems (including both intoxication and withdrawal), vulnerabilities including intellectual disability, and high levels of self-harm and suicide risk. A number of those who are assessed will also require transfer to hospital for their further management.

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Chapter 4. Suicide ideation amongst people referred for mental health assessment in police custody

4.1. Citation

Forrester, A., Samele, C., Slade, K., Craig, T., & Valmaggia, L. (in press). Suicide ideation amongst people referred for mental health assessment in police custody. The Journal of Criminal Psychology (accepted for publication on 27 June 2016).

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4.3. Acknowledgements

This service, and its evaluation, were supported by funds from Guy's and St Thomas' Charity.

4.4. Abstract

Purpose:

To examine the prevalence of suicide ideation amongst a group of people who had been arrested and taken into police custody, and were then referred to a mental health service operating in the police stations.

Design/methodology/approach:

A referred sample of 888 cases were collected over an 18-month period during 2012/13. Clinical assessments were conducted using a template in which background information was collected (including information about their previous clinical history, substance misuse, alleged offence, any pre-identified diagnoses, and the response of the service) as part of the standard operating procedure of the service. Data were analysed using a statistical software package.

Findings:

16.2% (N = 144) reported suicide ideation, with women being more likely to report than men. 82.6% of the suicide ideation sample reported a history of self-harm or a suicide attempt. Suicide ideation was also associated with certain diagnostic categories (depression, post traumatic stress disorder and personality disorder), a history of contact with mental health services, and recent (within 24 hours) consumption of alcohol or drugs.

Originality/value:

This evaluation adds to the limited literature in this area by describing a large sample from a real clinical service. It provides information that can assist with future service designs and it offers support for calls for a standardised health screening process, better safety arrangements for those who have recently

used alcohol or drugs (within 24-hours) and integrated service delivery across healthcare domains (i.e. physical healthcare, substance use, and mental health).

Key words:

Suicide ideation; police custody; mental health; screening; evaluation; integration

4.5. Introduction

The Independent Advisory Panel on Deaths in Custody in England and Wales reviewed all deaths in State custody during the 15-year period 2000 to 2014 and subsequently published this information in a national report (Independent Advisory Panel on Deaths in Custody, 2015). The 8,129 deaths described took place across a wide range of establishments, including prisons, police stations, secure training centres, immigration removal centres, approved premises and hospitals (the latter referring to the deaths of individuals who had mostly been detained in a hospital setting under the terms of the Mental Health Act 1983). Of these deaths, the largest group included people who had been detained under the Mental Health Act 1983 (n = 4,801, 59%), or who were detained in prison custody at the time of their death (n = 2,727, 34%). Almost a quarter of the total number were self-inflicted (n = 1,921, 24%), and of them the majority (n = 1,572, 82%) were men, while 18% (n = 349) were women. During this same period, there were 355 deaths in police custody, representing 4.4% of the total number of described deaths (this number having declined from 30 deaths in 2000 to 18 deaths in 2014, after reaching an earlier peak of 39 deaths in 2004 and a low point of 10 deaths in 2012). In 2014, 23% (n = 111) of all deaths that took place in State custody (n = 479) were identified as having been

self-inflicted (with natural causes identified as the largest single cause of deaths, in 67% of the total number). Meanwhile, a related national review of self-inflicted deaths in custody of people aged between 18 and 24 reported that during the seven-year period 2007 - 2014, there were 101 deaths in prison custody of people in this age group (Harris, 2015).

Within the general community, there were 6,233 suicides in the UK in 2013. The highest suicide rates were amongst people aged in their forties, with 2013 having the highest reported rate of male suicide since 2001 (Samaritans, 2015). The rate amongst men was 19 per 100,000 deaths, compared with 5.1 per 100,000 deaths amongst women, and “hanging, strangulation and suffocation” were reportedly the most common methods used (Office of National Statistics, 2015). Meanwhile, suicide rates in the criminal justice system are known to exceed those in the community, with rates in prisons having been described as up to six times higher than community samples (Fazel, Gran, Kling & Hawton, 2011). People who have just been released from prison present an increased risk of suicide when compared with the general population (Pratt, Piper, Appleby, Webb & Shaw, 2006), with significantly associated factors including histories of self-harm, alcohol misuse, mental health diagnosis, increasing age over 25, being released from a local prison, and requiring community mental heatlh team follow-up (Pratt, Appleby, Piper, Webb & Shaw, 2010). A recent population-based nested case-control study found that 13% of suicides in the general population had accessed community justice pathways in the period before their deaths (King, Senior, Webb, Millar, Piper, Pearsall, Humber, Appleby & Shaw, 2015). In another matched cased-control study, recent involvement at court was a factor in almost a third of people who died by

suicide (Cook & Davis, 2012), confirming earlier work demonstrating increased vulnerability to suicide and self-inflicted death amongst people in prison and offenders in community settings (McKenzie, Borrill & Dewart, 2013; Sattar, 2001). Self-harming behaviour is also more common in prisons, with such incidents being recorded in up to 6% of male prisoners and 24% of female prisoners every year, and a demonstrable link between acts of self-harm and subsequent completed suicide (Hawton, Linsell, Adeniji, Sariaslan & Fazel, 2014). In addition, high rates of suicide ideation persist amongst people in the criminal justice system, with reports describing a prevalence of suicide ideation of 41% amongst a community corrections sample (Gunter, Chibnall, Antoniak, Philibert & Hollenbeck, 2011), and a lifetime prevalence of up to a third in a random stratified sample of 996 people in prison (Larney, Topp, Indig, O'Driscoll & Greenberg, 2012).

The increased risk of suicide presented by people who are in contact with all stages of the criminal justice system is formally recognised within the national suicide prevention strategy for England (Department of Health, 2012). However, it is vital to understand that these risk factors are not fixed, and therefore to enable staff to use tools to intervene and share their concerns widely when risk arises (Prisons and Probation Ombudsman for England and Wales, 2014). In order to reduce the high numbers of deaths within prisons in England and Wales, initiatives aimed at wider systems improvements have been under-pinned by the central idea that *Suicide is Everyone's Concern* for the last 17 years (Her Majesty's Inspectorate of Prisons, 1999). This concept has been translated into operational service delivery through the *Assessment, Care in Custody and Teamwork* (ACCT) system, a nationally prescribed and

centrally co-ordinated care-planning system that requires all staff who come into contact with prisoners to be trained, and which sets minimum standards for the support and engagement of people who are thought to be at risk (Ministry of Justice, 2013). This model finds fairly broad support in the literature (Forrester & Slade, 2014) and more recently further evidence has started to emerge in support of models that ensure the engagement and co-operation of representatives of multiple agencies across health and justice areas, with the joint aim of custodial suicide prevention (Slade & Forrester, 2015).

By contrast, operational responses in police custody sit within the framework provided by the Police and Criminal Evidence Act 1984. This Act outlines the powers of the police and it has a major impact on the delivery of healthcare services in police custody. It has a broad remit that includes arrest procedures, general arrangements for detention, and the questioning and treatment of people by police officers. In accordance with the Act, “a person shall not be kept in police detention for more than 24 hours without being charged”, a necessary limitation to detention which also impacts upon healthcare assessments. Arrangements for the care and treatment of detained people are set out in the code of practice that accompanies the Act: in considering these “the custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable” if they are suffering from physical or mental health problems, or if they require clinical attention (Home Office, 2014). Protection is meant to be offered to adults who have been identified as mentally vulnerable during their detention and questioning, through the appropriate adult service (National Appropriate Adult Network, 2013). Additionally, as part of their further powers, Section 136 of the

Mental Health Act 1983 allows police officers to take a person “who appears to him to be suffering from mental disorder and to be in immediate need of care or control” to a place of safety, where further mental health assessments can then be arranged.

These operational responses are, in part, designed to enable services to deal with the high levels of morbidity (including mental and physical health problems, and substance misuse) that have been well-described in the police-custody healthcare literature (Ceelen, Dorn, Buster, Stirbu, Donker & Das, 2012; Payne-James, Green, Green, McLachlan, Munro & Moore, 2010; McKinnon & Grubin, 2010). Alongside these high levels of morbidity are some reports of high levels of suicide ideation amongst detained people, with up to half of these individuals being missed by existing police screens despite the known importance of early and effective screening (Noga, Walsh, Shaw & Senior, 2015; Noga, Foreman, Walsh, Shaw & Senior, 2015; McKinnon & Grubin, 2013). Yet despite these high reported levels of suicide ideation, there have been relatively few studies examining those who present with suicide ideation in police custody. By contrast, we understand much more about suicide risk in prison settings (Felthous, 2011), including which prisoners are at highest risk, and when in the process of imprisonment this risk is greatest (Forrester & Slade, 2014; Felthous, 2011). However, because the literature regarding suicide ideation and self-harming behaviour is more developed in prison settings than in police custody or courts, and given some of the commonalities that exist across the different parts of the criminal justice system pathway, this same literature is generally also co-opted to assist in understanding these issues as they arise in police custody. As the links between self-harming

behaviour and completed suicide are progressively understood, (Hawton, Linsell, Adeniji, Sariaslan & Fazel, 2014), the role of earlier trauma in cases of completed suicide is also increasingly identified (Oakes-Rogers & Slade, 2015). In addition, examinations of people in prison who have survived serious suicide attempts have assisted wider understanding of the psychological processes involved. In male prisoners, for example, adverse events such as relationships coming to an end, or bereavement, are known to be important factors (Rivlin, Fazel, Marzano, & Hawton, 2011). Mental health concerns (such as substance withdrawal and psychiatric symptoms) and issues related to sentencing are also described, with many of these individuals having also describing suicidal intentions and visual images relating to suicide in the period before a suicide attempt (Rivlin, Fazel, Marzano, & Hawton, 2011). In female prisoners, hopelessness and impulsivity have been described as important factors, and a background of repeated suicide attempts, and suicide ideation, is often present (Marzano, Fazel, Rivlin, & Hawton, 2011).

Within this context, and recognising the general paucity of literature in the particular area of suicide ideation in police custody settings, this project aimed to examine the prevalence of suicide ideation amongst a group of people who had been arrested and taken into police custody, and were then referred to a mental health service operating in the police stations. It also aimed to describe any features that were associated with these suicidal ideas across a range of domains (including clinical factors such as *self harm and suicide attempt history*, *current diagnostic categorisation*, *mental health history* and *current substance use*, and offending and service factors such as *offending behaviour and criminal justice system experience* and *service response*). It also

aimed to consider whether any recommendations could improve healthcare service delivery in this area.

4.6. Method

Setting

The sample was collected as part of an evaluation of a mental health service operating across two police stations in one borough of south London. The service was funded by a grant provided by Guy's and St Thomas' Charity and the service was provided by the local National Health Service (NHS) Mental Health Trust. The service was physically located in the police stations, where referrals were received and assessments were undertaken by nursing staff who were employed by the mental health service.

Sample

A sample of 888 cases from a consecutive referred sample had sufficient data for which comparative analysis could be undertaken. These cases were collected over an 18-month period during 2012 and 2013, and of this group 144 (16.2%) reported current suicide ideation in police custody. There were 174 women and 709 men in the sample (of whom, respectively, 20.1% and 15.1% reported current suicide ideation), although the gender of 5 cases was not recorded. The age range for the suicide ideation group range from 19 - 72 years (M = 35.2 years, SD = 9.6) and for the non-suicide ideation group the age ranged from 18-79 years (M = 35.3, SD = 9.6).

Procedures

As highlighted in the introduction, police powers and procedures in respect of arrest and subsequent detention in custody are set out in the Police and Criminal Evidence Act 1984. The terms of this Act allow police constables

to arrest people in respect of whom there is reasonable suspicion that they are about to commit, are in the act of committing, or have committed an offence. After being arrested and brought into police custody, the police must charge a person within 24-hours (or apply for a longer period of detention of 36 or 96 hours in cases where the crime is thought to be sufficiently serious). During this time, the police are obliged to follow a number of processes that are meant to protect the rights of individuals, these processes being set out in relevant codes of practice (Home Office, 2014). As part of the initial process, custody sergeants apply a nationally agreed basic health screen - although this same screen, which is presently in use throughout England and Wales, has been shown to be inadequate at assessing for the presence of a range of healthcare problems (including physical health problems such as head injuries and alcohol withdrawal, and mental health problems including suicide risk) (McKinnon & Grubin, 2014).

In the current study, after the basic health screen had been applied, detainees could then be referred on for further physical healthcare (e.g. to a primary care nurse, or a Forensic Medical Examiner - i.e. a primary care doctor) if this was considered useful or appropriate. Detainees could also be referred to the mental health service at any stage in the process, either directly by the custody sergeant, or after they had initially been reviewed by a primary care clinician (this referral mechanism having been introduced by the mental health service in order to ensure that a service would be offered to as many people as possible, in recognition of the high morbidity levels that had been anticipated).

After a referral was made, the mental health service then sought to assess all referred detainees within a four-hour period (this target being

deliberately in keeping with targets for acute care assessment elsewhere in the National Health Service). A clinical assessment was conducted using a template in which background information was collected (including information about their previous clinical history, substance misuse, alleged offence, any pre-identified diagnoses, and the response of the service). All of this information was collected as part of the standard operating procedure of the service. The collected information was then entered into an anonymous database on a weekly basis and presented for further analysis using a statistical software package.

Following an assessment, all available information was synthesised to enable a clinical decision regarding the most suitable onward pathway. In cases where there was thought to be a risk of suicide (i.e. cases in which suicide ideation had been disclosed), consent was sought to share this information with other agencies.

Data analysis

All analyses were performed using SPSS version 22 (IBM Corp, 2013). In order to compare police custody detainees who reported suicide ideation with those who did not, a series of Chi-square analyses were undertaken. Post-hoc power analysis confirmed that 90% power to detect a large effect size (>.50) was achieved with the sample size, with an X2 value greater than 2.7. All variables which had fewer than five cases in each cell were removed from the analysis.

Ethical considerations

Appropriate approval for this evaluation was obtained from the relevant body within the local National Health Service organisation.

4.7. Results

Socio-demographic factors

No significant differences were recorded for the suicide ideation sample compared to the non-suicide ideation sample across a range of variables, including: their employment (13 vs 17%); whether they were receiving benefits (67 vs 68%); whether they had children (44% vs 38%); whether they were homeless (12% vs 8%); and whether they were married or cohabiting (12 vs 13%).

There were no significant differences for most ethnic groups, apart from Mixed heritage arrestees who were over-represented in the suicide ideation sub-group. The ethnic categories for the sample, by suicidal ideation group (i.e. suicide ideation and no suicide ideation), are reported in Table 1 below:

Table 1:

Ethnic categories for arrestees by suicide ideation sub-groups, and English not as first language

	Suicide ideation (N = 144)	**No suicide ideation (N = 744)**			
Broad ethnic Group	**Number (%)**	**Number (%)**	**Chi2**	**p-value**	**95% CI of difference**
White	75 (52.1)	342 (46)	1.77	.107	-3.2 – 15.4
Black	52 (36.1)	274 (36.9)	.03	.47	-9.7 – 8.3
Asian	3 (2.1)	22 (3)	.339	.401	-3.9 – 2.2
Mixed	8 (5.6)	85 (11.4)	4.45	.02*	-10.7 - -1.1
Chinese	2 (1.4)	5 (0.7)	.79	.318	-1.7 – 3.1
Other	4 (2.8)	15 (2)	.331	.373	-2.5 – 4.0
English is not first language	24 (16.7)	188 (25.3)	4.91	.015*	-15.8 - -1.3

As outlined in Table 2, the suicide ideation group were also more likely to have English as their first language.

Clinical factors

Self harm and suicide attempt history. The analyses confirmed that arrestees reporting suicide ideation were more likely to have a history of self-harm, or a suicide attempt, with 82.6% of the suicide ideation sample disclosing both previous harmful behaviours.

Current diagnostic categorisation. In relation to identified diagnostic category, people with suicide ideation were under-represented amongst those with schizophrenia or psychosis, and over-represented amongst the depression, post traumatic stress disorder (PTSD) and personality disorder categories. There were no significant differences between groups regarding the likelihood of substance use disorders or intellectual disability.

Mental health history. The group presenting with suicidal ideas were more likely to have previously been known to mental health services, to have a previous mental disorder, and to be in receipt of psychotropic medication. There was no significant difference in the likelihood of prior admission to psychiatric hospital.

Current substance use. The suicide ideation group were more likely to have consumed alcohol or drugs in the 24 hours before they were brought into police custody, with a history of alcohol consumption being most likely. The reported numbers for all other substances (apart from cannabis use) within the suicide ideation group were too low (< 5) for further analysis.

Offending and service factors

Offending behaviour and criminal justice system experience. There were no significant differences in alleged offences, or in having a previous violent conviction, between the groups. However, the suicide ideation sub-group was more likely to have been on bail when arrested.

Service response. The suicide ideation sub-group was more likely to be seen by a health professional in the police station. There was no significant difference in whether they were considered fit for interview.

Table 2:

Frequency and chi-square analysis of difference between arrestees with suicide ideation

Variable	Suicide Ideation N = 144 (%)	No current suicide ideation N = 744 (%)	Chi^2	p- value	95% CI of difference
Previous history					
Previous self-harm or suicide attempt	115 (79.9)	393 (52.8)	36.03	<.001**	19.2 – 34.9
Previously known to MH services	110 (76.9)	486 (65.3)	5.52	.011*	2.9 - 19.2
Previous Mental Disorder	136 (94.4)	605 (81.3)	15.05	<.001**	8.0 - 18.2
Previous medication	88 (68.1)	393 (52.8)	3.34	.041*	-0.8 – 17.4
Previous admission to hospital	65 (58.6)	315 (42.3)	1.46	.136	-6.5 – 12.1
Current substance use					
Alcohol or Drug Use in last 24 hours	84 (58.3)	334 (44.9)	4.63	.019*	4.2 – 22.6
Current alcohol use	84 (58.3)	367 (49.3)	3.91	.029*	0.2 – 18.2
Current cannabis use	14 (9.7)	83 (11.2)	.255	.369	-7.2 – 4.3
Offence charge					
Violence offence	41 (28.5)	220 (29.6)	.070	.438	-9.6 – 7.4
Sexual offence	32 (22.2)	155 (20.8)	.140	.391	-6.4 – 9.2
Drugs offence	37 (25.7)	171 (23)	.494	.273	-5.5 – 10.9
Arson offence	5 (3.5)	50 (6.7)	2.19	.093	-7.1 – 0
Fraud offence	15 (10.4)	70 (9.4)	.142	.40	-4.8 – 6.8
Threat offence	11 (7.6)	58 (7.8)	.004	.555	-5.0 – 4.7
Previous criminal record	115 (79.9)	613 (82.4)	.523	.269	-10 .0 – 5 .0
On bail when arrested	30 (22.4)	110 (15.3)	4.11	.032*	-1.5 – 13.6
Previous violent convictions	80 (55.6)	407 (54.7)	.035	.462	-8.4 – 10.1
Service response					
Not fit for interview	29 (21.2)	131 (18.8)	.040	.298	-5.0 – 10.0
Seen by Operation Emerald Worker	52 (36.6)	226 (30.7)	1.92	.10	3.2 – 14.7
Seen by arrest referral worker	28 (19.9)	113 (80.1)	3.25	.05*	-3.1 – 11.6
Seen by forensic medical examiner	30 (21.3)	127 (17.3)	1.27	.157	-3.8 – 11.3
Seen by any health professional	86 (61.4)	378 (52)	4.20	.025*	0.3 – 18.1
Diagnostic and Clinical					
Schizophrenia/Psychosis	22 (15.3)	197 (26.5)	8.15	.002**	-18.2 - -4.1
Substance Use Disorder	47 (32.6)	218 (29.3)	.642	.24	-5.4 – 12.1
Depression	72 (50)	244 (32.8)	15.57	<.001**	7.9 – 26.4
PTSD	22 (15.3)	62 (8.3)	6.79	.01**	0.3 – 13.6
Personality Disorder	29 (20.1)	85 (11.4)	8.18	.005**	1.4 – 16.1
Intellectual Disability	11 (11.8)	43 (8.2)	1.28	.173	-3.2 – 6.9

4.8. Discussion

In this study we aimed to examine the prevalence of suicide ideation amongst people in police custody who were referred to a mental health service operating in the police stations. Our secondary aims were to describe any features that were associated with this suicide ideation, and to consider what could be learned to improve healthcare service delivery in police custody.

Overall, a substantial number from this referred sample reported suicide ideation during their time in police custody (144; 16.2%). with women reporting a greater proportion of suicidal ideas than men. Yet although these high reported levels of suicidal ideas are concerning, they are broadly consistent with results that have been reported in the wider literature. One group described suicidal ideas in 10.5% of a sample of 237 detainees (McKinnon, Srivastava, Kaler & Grubin, 2013), while another described a history of self-harming behaviour in 54% of women who were referred to a mental health service operating in police custody (Scott, McGilloway & Donnelly, 2009). The results are also in keeping with research findings from the lower (Magistrates') courts, suggesting that the effect may operate across the whole criminal justice pathway, rather than merely in one part of it (Shaw, Creed, Price, Huxley & Tomenson, 1999). These results also compare with reports from the general population for all suicidal ideation of between 1.1 and 19.8% (Casey, Dunn, Kelly, Lehtinen, Dalgard, Dowrick & Ayuso-Mateos, 2008) and with research demonstrating that 13% of all suicides taking place in the general population had been inside the criminal justice pathway in the period before their death (King, Senior, Webb, Millar, Piper, Pearsall, Humber, Appleby & Shaw, 2015). The higher levels of suicide ideation amongst women are also consistent with

our existing understanding, and with resulting policy initiatives in this area (Corston, 2007). The fact that people who reported suicide ideation were more likely to have a history of self-harm, or a prior suicide attempt, indicates a group in which a persistence of vulnerabilities contributes to their risk in police custody. The results are stark, with 82.6% of the suicide ideation sample reporting both prior harmful behaviours. It suggests that some of the risk in police custody is imported from the community, rather than merely arising as a consequence of detention. However, it should be understood within the context of our existing understanding that those with the greatest level of vulnerability have higher levels of mental distress in police custody (Baksheev, Thomas & Ogloff, 2012). The over-representation of suicide ideation amongst those from particular diagnostic categories (depression, post-traumatic stress disorder and personality disorder) is also consistent with this model, and with our understanding of the psychopathology associated with these conditions (Hawton & James, 2005; Harris & Barraclough, 1997). Taken as a whole, these finding provide support for calls for improved screening, with the aim of improved diagnostic precision amongst all police custody detainees (McKinnon & Grubin, 2014).

The over-representation of suicide ideation amongst those who have a history of mental disorder, who are already known to mental health services, and who are already taking medication, supports the idea that contact with the criminal justice system can occur at times of crisis. It is known, for example, that some people are more likely to come into contact with the criminal justice system as their mental state deteriorates during a first psychotic episode (Bhui, Ullrich, Kallis & Coid, 2015). The presence of these high levels of distress, and

their association with underlying established mental disorder, makes a further case for the *liaison and diversion services* that are currently being piloted across England and Wales with a view to wider introduction (Bradley, 2009; Srivastava, Forrester, Davies & Nadkarni, 2013). It also, however, raises questions about the extent to which the support and treatment that is meant to be provided by community mental health services operating within the National Health Service (NHS) has a wider role in the prevention of offending behaviour (Independent Mental Health Taskforce, 2016), recognising the role that mental illness plays here alongside other criminogenic factors (Ministry of Justice, 2013).

Within this sample, there was a clear association between suicide ideation and the use of alcohol and drugs in the 24-hour period before arrest. Within the wider literature, alcohol dependence in particular is known to be associated with suicidal behaviour, and there is also emerging understanding of the adverse role that acute intoxication can play (Kaplan, McFarland, Huguet, Conner, Caetano, Giesbrecht & Nolte, 2012). This indicates the need for a robust service response within both primary care and mental health services in police custody, and, possibly, for a renewed strategy for approaching those who are intoxicated while they are in police custody. Brief screening and interventions, for example, are thought to be feasible in this setting (Chariot, Lepresle, Lefevre, Boraud, Barthes & Tedlaouti, 2014), and there is some evidence that an improved strategy for managing intoxicated people in police custody can lead to safety improvements (Aasebo, Orskaug & Erikssen, 2016).

As regards service response, it is encouraging to note that the suicide-ideation sub-group was more likely to have been seen by an arrest referral

worker, or another health professional, prior to their mental health assessment. It indicates that this service was successfully identifying people at greatest risk, in keeping the stated policy aim of assessing people as early in the process of their detention as possible (Bradley, 2009). It also provides evidence for the integrated working that it thought to be particularly necessary in this field (Till, Exworthy & Forrester), and it suggests that a degree of co-operation is in fact occurring at ground level, despite a lack of join-up in the service commissioning process (Forrester, Valmaggia & Taylor, 2016). Within this study, information regarding suicide risk was used in individual cases to plan onward care and management and consent was requested to share this information with other agencies to assist in keeping the individual safe. Although code C of the Police and Criminal Evidence Act 1984 clearly sets out how mentally disordered or otherwise vulnerable people in custody should be managed, there is little specific guidance regarding the management people with suicide ideation. Further, given established difficulties in transferring risk information across criminal justice system pathways (Roberts, Senior, Hayes, Stevenson & Shaw, 2011) there is a need for further research to understand how and where this works best to enable systemic improvement. However, given the necessity for close multi-agency cooperation in managing risk (Prisons and Probation Ombudsman for England and Wales), it would seem sensible to consider a future in which a joint vehicle for risk management, similar to the ACCT process in design, is piloted and reviewed, with a view to its establishment across the whole criminal justice pathway.

This evaluation has a number of strengths and weaknesses. As regards the former, the sample evaluated is larger than those described elsewhere in

the literature, and it adds some new evaluation findings to the relatively small existing number of papers in this particular field. Further, in offering an evaluation of a real service operating in police custody, it provides a ground level view that could assist with the development of other similar services. In particular, it provides useful information regarding the identified suicide ideation sub-group, including their associated characteristics. As regards weaknesses, this evaluation took place in only one service, and its results may be geographically limited. Further, although a number of variables were collected, diagnostic instruments could not be used because the service operated a clinical priority within considerable time constraints. Although the service assessed those who were referred to it, many other individuals were received into police custody who were not referred, and the extent to which this un-assessed group also presented with suicide ideation is unknown.

The results of this evaluation provide support for a number of recommendations. The first of these is for improved diagnostic screening within these services as standard – including screening for a history of self-harming behaviour, previous suicide attempts, and history of mental health problems. This recommendation already finds support elsewhere in the literature (Noga, Walsh, Shaw & Senior, 2014; McKinnon & Grubin, 2013). The second recommendation is to review safety improvements for those who have recently used drugs or alcohol, building on results elsewhere that have described safety improvements with this group (Aaesebo, Orskaug & Erikssen, 2016). The third recommendation is for further research in this area to better understand the link between suicide ideation in police custody and self-harm or suicide within in the criminal justice pathway, or after leaving it. The wider field of suicide prevention

is one in which there is a recognised paucity of randomised controlled trials (Zalsman, Hawton, Wasserman et al., 2016), but given the high proportion of deaths by suicide within criminal justice pathways (King, Senior, Webb et al., 2015), there is a strong argument for a specific research focus in this area that is marked by its vulnerability. The fourth recommendation is to ensure optimal integration between mental health, substance misuse and physical health services within police custody (as is the aim across the whole criminal justice pathway), obviating the need for referrals between different services (Till, Exworthy & Forrester, 2014). This last recommendation, while progressive and aspiration in its intention, also recognises that limitations exist within current commissioning and funding arrangements (Forrester, Valmaggia & Taylor, 2016). Nonetheless, given the apparent value of multi-agency collaboration in reducing risk (Prison and Probation Ombudsman for England and Wales), a joint vehicle to enable risk management across the entire criminal justice pathway would now be a useful approach to pilot.

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Chapter 5. Healthcare services in police custody in England and Wales

5.1. Citation

Forrester, A., Valmaggia, L., & Taylor, P. (2016). Healthcare services in police custody in England and Wales (recent government u turn leaves police healthcare adrift from the NHS). *British Medical Journal, 353*, i1994.

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5.3. Article content

In December 2015, the UK government announced that planned changes to the commissioning of healthcare for people held in police custody in England and Wales would not proceed. These changes had been well considered (having been in planning since a key report by Lord Bradley in 2009[1]), set out formally, and described as one route to securing excellence.[2] The government announcement, however, means that the commissioning of these specialist health services will remain with police and crime commissioners instead of being transferred to the National Health Service. This sets police

healthcare apart from all other healthcare services, including those that are provided in other parts of the criminal justice pathway.

The decision represents a missed opportunity. It will prevent much needed service development and could set back current healthcare delivery. It represents a policy reversal that flies in the face of several years' preparation. It seems to have been financially driven,[3] but had the proposed transfer to NHS commissioning driven service improvements as expected, the change could have improved health outcomes substantially, and ultimately saved money.

Forty one police and crime commissioners in England and Wales were elected in 2012 and now have a key role in setting local objectives and budgets. Their overall budget is in excess of £8bn, funding a workforce of over 200 000 people. This workforce is in place to deal with up to 6.6 million crime incidents[4] and over one million arrests a year, although arrests have been consistently falling since 2007.[5]

Many of these large numbers of people may not have sought healthcare in the community despite having a complex range of conditions that require investigation and treatment[6] and may be acutely life threatening.[7] The importance of providing healthcare screening after arrival in police custody is well established, although the screening methods currently used nationally require improvement8 - something that could have been achieved through the transfer of commissioning responsibilities.

The prevalence of health disorders among people taken into police custody resembles the prevalence within the prison population - perhaps unsurprisingly given that many of them will ultimately enter prison, whether

transiently to await trial or for a custodial sentence.[9] They are, however, often much more acutely ill than all but the newest prisoners.

In prisons, the combination of high morbidity[10] and commitment to equivalence of healthcare[11] has led to relevant healthcare services being commissioned from the NHS since 2006.

Although this handover of commissioning responsibility took a decade after the publication of the landmark report Patient or Prisoner[12] in 1996, recognition that these changes identified substantial unmet needs[13] should weigh against abandoning, or even delaying, similar reforms for those in police custody.

Furthermore, failure to see through the commissioning changes goes against current international trends in progressive thinking about healthcare systems, which highlight the need for service integration across complex clinical pathways.[14]

Lord Bradley's proposal for the development of liaison and diversion services - integrated across the whole criminal justice pathway and with other relevant services in order to provide information where required and transfer people away from custodial care at earlier points in the criminal justice pathway - is still government policy. There is increasing recognition that these services can be effective,[15] and mounting evidence that healthcare interventions that broadly sit within the liaison and diversion portfolio, such as court based mental health interventions and intensive drug treatments can ultimately save money.[16]

The government's U turn on commissioning health services in police custody seems set to leave these services disconnected from the NHS as a whole, and from one another, through disjointed commissioning. This is a far cry

from the seamless integration that had been sought, and that is still government policy.[14] The decision seems more focused on a short term financial fix than longer term strategic health and economic gain.

We believe that consistent NHS based health commissioning arrangements across the entire criminal justice pathway would result in considerable improvement in the safety of the community and those arrested as well as cost benefits for the government. We therefore hope that this position can be restored at the earliest possible opportunity.

5.4. Declaration of competing interests

Competing interests: We have read and understood BMJ policy on declaration of interests and declare AF's and LV's NHS employer provides healthcare services in the criminal justice system (including police stations, courts and prisons) Provenance and peer review: Commissioned; not externally peer reviewed.

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Chapter 6. Prison Mental Health In-reach: The Effect of Open Referral Pathways

6.1. Citation

Hopkin, G., Samele, C., Singh, K., Craig, T., Valmaggia, L., & Forrester, A. (2016). Prison mental health in-reach: the effect of open referral pathways. *Psychiatry, Psychology and Law*, 1-7.

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6.3. Abstract

In England and Wales, mental health in-reach teams manage high levels of mental disorder in prisons, but problems with reception screening and referral triage have been identified. As one potential solution, we examined the effect of

an open referral pathway upon one in-reach team by evaluating its referrals and caseload across two time periods (in 2008 and 2011). There was a doubling of team referrals (from 101 to 203) with significantly improved identification of people with no mental health history. There was further evidence for a lowering of thresholds for referral and assessment, an approach that can be seen as helpful within a system that is known to under-identify mental health problems. Despite limitations, this evaluation offers some evidence for the effectiveness of open referral systems. It also raises questions about the potential effects of liaison and diversion services that are presently being piloted for national introduction.

Key words: custody; in-reach; mental health; prison; prisoner; reception referrals; screening.

6.4. Introduction

There is well-established international evidence for high levels of psychiatric morbidity amongst prisoners, with rates of severe mental illness (SMI) between two and four times community levels (Fazel & Danesh, 2002; Fazel & Seewald, 2012). In England and Wales, these high prevalence rates have been confirmed by a series of single-site studies (Birmingham, Mason, & Grubin, 1996; Brooke, Taylor, Gunn, & Maden, 1996; Gunn, Maden, & Swinton, 1991) and a comprehensive examination of the wider prison estate (Singleton, Gatward, & Meltzer, 1998). These high levels of morbidity indicate the need for appropriate services to assess and treat prisoners with mental health problems, and in England and Wales such services are commissioned (and often provided) by the National Health Service (NHS). These service developments have largely been driven by policy, according to the international principle of

equivalence (Srivastava, Forrester, Davies, & Nadkarni, 2013; Till, Forrester, & Exworthy, 2014), and as a consequence prison mental health in-reach teams have now been established for over a decade. Their main original remit was to manage prisoners with SMI using a service model that was closely based upon mental health teams operating in the community, and thereby also to improve collaboration between prison and community health services (Department of Health and HM Prison Service, 2001).

However, within a relatively short time it became apparent that this remit was widening, driven by both the organisational context and high levels of need (Ricketts et al., 2007). As this widening was further extended by national policy that made a broader remit explicit, 'mission creep' was identified as affecting these services after they had been operating for only a handful of years (Steel et al., 2007).

Despite these initial problems, prison mental health in-reach services have generally been welcomed as a useful vehicle for managing prisoners presenting with mental health problems (Samele, Forrester, Urquia, & Hopkin, 2016), and greater levels of integration with primary care and forensic psychology services have been seen as beneficial (Forrester, MacLennan, Slade, Brown, & Exworthy, 2014). Yet although the introduction of these services has also coincided with improvements in national arrangements for prison health screening, many prisoners with SMI have remained unidentified during their time in prison (Birmingham, Gray, Mason, & Grubin, 2000; Senior et al., 2013). Although health screening upon reception into prison has been widely adopted as international best practice, there are inherent limitations with screening processes which may to some extent be immutable (Martin, Colman,

Simpson, & McKenzie, 2013). Given these limitations, various local screening adaptations have been sought, including introducing mental health expertise into prison reception (e.g. Brown, Cullen, Kooyman, & Forrester, 2015) and using a second layer of screening to improve detection (e.g. Jarrett et al., 2012). To supplement these existing processes, mental health in-reach teams have also tended to be reliant upon referrals which they receive from other agencies (Birmingham et al., 2000).

In recognising the need to seek further improvements in the detection of mental health problems amongst prisoners, and the limitations of existing triage mechanisms (Brooker & Gojkovic, 2009), this project examines the effect of an open referral pathway upon one prison mental health in-reach team by evaluating its referrals and caseload across two time periods (in 2008 and 2011). Given the developmental nature of prison mental health services, rapid changes in their remit over a relatively short number of years, and the relative paucity of literature documenting the ground-level experience of prison in-reach teams, it also adds to the available literature by documenting the development of one such team over time.

6.5. Method

Setting

This evaluation took place in a publicly-owned male category-B remand prison in South London. It has an operational capacity of approximately 800 prisoners, and it receives prisoners from several local magistrates' and crown courts. At the time of the study there was a high population turnover, with over half of all arrivals being un-sentenced and another fifth serving short sentences of under 12 months.

Team

The mental health in-reach team was originally established in 2002, and was provided by an NHS team working in the prison on weekdays. The service functioned according to a community mental health team model, with input from nursing staff, psychiatrists and psychologists. An open referral system was adopted in 2008, and between 2008 and 2011 it was extended into the wider offender health pathways which served the prison (i.e. into local police and court liaison and diversion services), with clinicians providing services across multiple locations after 2009, rather than only in the prison. This meant that instead of taking referrals only from within primary care, the team now accepted them from a wider range of potential sources (including, for example, community mental health or social care services, healthcare services operating in local police stations and courts, prison officers, legal representatives, families, and prisoners themselves).

Procedure

Referrals to the mental health in-reach team during an 18-week period in 2008 (Forrester et al., 2014) were compared with referrals during a 16-week period in 2011. Prison healthcare records (including reception screens, initial assessments and subsequent psychiatric and case management entries contained within the prison's electronic health-care records) were also reviewed to collate information on a range of demographic, forensic and clinical variables.

Analysis

Descriptive statistics were used to describe demographic, clinical and forensic characteristics in the sample and Fischer's exact tests were used to examine the differences between the referrals in 2008 and 2011. For several

variables, categories were combined to achieve suitable numbers for analysis. Missing variables were present in less than 5% of cases and were not systematically related to outcome, so were excluded from analyses. SPSS v20 (IBC Corp, 2011) was used to conduct analyses. A multivariate logistic regression model was conducted using a stepwise variable selection procedure. Variables that had an association ($\rho < .2$) with acceptance onto the caseload in univariate tests were entered into the regression model and subsequently variables in the model that were shown to be associated ($\rho < .1$) with acceptance were retained. Variables were then re-entered and removed to ensure that confounding variables were included in the final analysis. Collinearity of the variables was below the accepted level.

Ethical Considerations

The clinical effectiveness group of the local NHS trust provided approval for this service evaluation.

6.6. Results

Comparison of all Referrals in 2008 and 2011

There were 101 referrals to the team during the 18 weeks in 2008 compared to 203 referrals during the 16 weeks in 2011. A total of 60 (59%) of the 101 referrals were assessed and accepted onto the caseload in 2008, and this number increased to 141 (69%) in 2011, as outlined in Table 1 below. The time taken from assessment to referral was similar across the samples, with the majority being seen within two days (2008, 67%; 2011, 68%) and only a small number waiting more than eight days.

The demographic characteristics of those referred to the team is largely similar in both samples. The age of those referred ranges from 18 to 63 years,

and in both samples over half of referrals are aged between 21 and 35 years. Referrals from 2008 and 2011 do not differ significantly on variables related to marital status, ethnicity, employment or residency status, and the sample reflects the high level of deprivation in both the prison and the area of inner London which it serves, with high levels of unemployment (92%) in both samples.

With regard to forensic variables, the 2008 sample has a higher proportion of remand prisoners (73%) than the 2011 sample (53%), with a reverse trend shown for sentenced prisoners (2008, 19%; 2011, 33%). This difference is significant ($\rho < .001$). The 2011 sample has a higher proportion of prisoners charged with or sentenced for burglary (16%) compared to 2008 (5%), and conversely a smaller proportion of less serious acquisitive offences (2008, 29%; 2011, 18%), but there are no such differences for other offences, and no significant differences for offence categories.

Table 1.

Referral information.

	2008 Sample		2011 Sample	
	n	%	n	%
Referrals accepted to in-reach	101	100.00	203	100.00
No	41	40.59	62	30.54
Yes	60	59.41	141	69.46

For clinical variables, there are several important differences (see Table 2). The 2011 sample has a higher proportion of referrals with no psychiatric disorder (31%) compared to 2008 (12%). The proportion with a psychotic disorder is almost identical across the samples, but the increase in those with no disorder in 2011 is accompanied by a reduction in those with all other recorded disorders. The differences are significant ($\rho = .001$). Further, the 2011 sample has a higher proportion of referrals with no previous contact with services (2008, 31%; 2011, 49%) and referrals with no previous admission to a psychiatric hospital (2008, 34%; 2011, 65%); both of these differences are significant ($\rho = .002$; $\rho < .001$).

Table 2.

Clinical information.

	All referrals				Accepted referrals			
	2008 Sample		2011 Sample		2008 Sample		2011 Sample	
	n	%	n	%	n	%	n	%
Primary diagnosis								
None given	12	11.88	63	31.03	0	0.00	24	21.98
Psychotic disorder	46	45.54	92	45.32	38	63.33	84	59.57
Affective disorder	15	14.85	22	10.84	9	15.00	16	11.35
ADHD	5	4.95	9	4.43	4	6.66	6	4.26
PTSD	4	3.96	3	1.47	2	3.33	2	1.42
Learning disability	4	3.96	1	0.49	3	5.00	1	0.71
Personality disorder	15	14.85	12	5.91	4	6.66	1	0.71
Substance misuse	0	0.00	2	0.98	0	0.00	0	0.00
Community care								
No previous mental health care	31	30.69	100	49.26	7	11.67	53	37.59
Previous mental health care	70	69.31	103	50.74	53	88.33	88	62.41
Inpatient admission								
No inpatient admission	34	33.66	132	65.02	5	8.33	85	60.28
Previous inpatient admission	67	66.34	71	34.98	55	91.67	56	39.72

Note: ADHD = attention deficit hyperactivity disorder; PTSD = post-traumatic stress disorder.

Table 2 also shows the differences in clinical variables for those who were accepted onto the team's caseload in 2008 and 2011. In 2011, significantly more prisoners with no diagnosed disorder were accepted onto the caseload (2008, 0%; 2011, 17%; ρ = .001), and as with the wider sample of all referrals, there are differences in the number of accepted prisoners with no previous contact with services (2008, 12%; 2011, 38%) and with no previous psychiatric admissions (2008, 8%; 2011, 60%). Both differences are significant (ρ = .001; p < .001).

The results of a multivariate logistic regression, conducted to determine which variables across both samples are associated with acceptance onto the in-reach team case- load, can be seen in Table 3. The variables which are significantly associated with acceptance onto the caseload are as follows: being referred in the 2011 sample (p < .001); psychotic disorder (ρ < .001); affective disorder (ρ = .001); attention deficit hyperactivity disorder (ADHD; ρ = .005); previous mental health care (ρ < .025); and inpatient admission (ρ < .011). Having a violent index offence of assault (ρ = .036) or homicide (ρ =.037) is also significantly associated, but should be seen within the context of a small number of cases and large confidence intervals.

Table 3.

Multivariate logistic regression for outcome of acceptance onto the caseload.

	Unadjusted odds ratio	Adjusted odds ratio	Standard error	p value	95% CI (adj. odds ratio)
Referral sample					
2008 sample	Reference				
2011 sample	1.55	4.33	1.69	**<.001***	**2.01-9.32**
Offence					
Acquisitive	Reference				
Offences against property	2.51	2.30	1.65	.245	0.56-9.40
Sexual offence	1.01	0.92	0.64	.908	0.23-3.63
GBH/wounding	2.22	2.22	1.50	.241	0.59-8.40
Assault*	2.59	2.83	1.40	**.036**	**1.07-7.46***
Homicide*	2.35	7.19	6.81	**.037**	**1.13-45.96***
Licence recall	1.18	0.53	0.54	.534	0.74-3.86
Robbery	2.74	3.01	1.89	.080	0.88-10.32
Other	1.16	1.27	0.56	.582	0.54-3.02
Primary diagnosis[b]					
No diagnosis	Reference				
Psychotic disorder*	14.95	11.99	5.26	**<.001**	**5.07-28.31***
Affective disorder*	4.01	5.01	2.47	**.001**	**1.91-13.16**
ADHD*	5.21	8.09	6.06	**.005**	**1.86-35.16***
PTSD	2.78	4.85	4.46	.086	0.80-29.42
Learning disability	8.33	14.13	19.25	.052	0.98-203.93
Personality disorder	1.67	1.63	0.90	.372	0.56-4.80
Community care					
No previous mental health care	Reference				
Previous mental health care*	5.21	2.31	0.86	**.025**	**1.11-4.80***
Inpatient admission					
No inpatient admission	Reference				
Previous inpatient admission*	3.47	2.57	0.96	**.011**	**1.24-5.36***

[a]Multivariate logistic regression model shown was constructed using a stepwise variable selection procedure retaining all variables that had an association with acceptance to the caseload (p < .2) and subsequently removing from the model variables that were not significant (p < .5) and did not have a confounding

*effect; [b]Substance misuse excluded due to lack of cases and learning disability included but with limited cases; *Significant at the p < .05 level. ADHD = attention deficit hyperactivity disorder; CI = conficence interval; GBH = grievous bodily harm; PTSD = post-traumatic stress disorder.*

6.7. Discussion

As prison mental health in-reach teams have developed across England and Wales over the last 15 years, variations in service delivery have become apparent through national surveys (e.g. Brooker & Gojkovic, 2009; Forrester et al., 2013), but the literature describing the ground-level functioning of these services is limited (e.g. Forrester, Chiu, Dove, & Parrott, 2010; Forrester et al., 2014; Hales, Somers, Reeves, & Bartlett, 2015). Over this period, while teams have undergone rapid changes in their remit, problems with screening and triage systems have also been identified (Brooker & Gojkovic, 2009). Further, although working across criminal justice areas has been recommended as best practice by national policy (Bradley, 2009), most teams have historically played no role in wider criminal justice liaison and diversion services (Brooker & Gojkovic, 2009).

Within this national context, this service experienced a doubling of its referral rate after an open referral system was introduced and then extended across wider criminal justice clinical pathways (with clinicians working across multiple locations after 2009, including the prison and the main local magistrates' court). This doubling of referral rates between 2008 and 2011, during a period when there were no identified changes to the prison, its population, or its feeder criminal justice system pathways, strongly suggests a causative role for the extension of the open referral system across clinical pathways leading into, and within, the prison. Further, the fact that the 2008 sample contained a higher proportion of remand (pre-trial) prisoners appears to confirm a subsequent widening of the net to include greater numbers of prisoners who were convicted, un-sentenced, or sentenced, consistent with the

general intention of lowering thresh- olds. The incorporation of significantly greater numbers with no identified psychiatric disorder in the 2011 sample is more difficult to explain, but it does also suggest a general lowering of thresholds for both referral and assessment. This appears to be consistent with the general principles of the open referral system and its pathways and can be seen as a helpful approach within a system which is known to under-identify mental health problems. The significantly improved identification of those with no history of contact with services, including hospital admission, appears as an unintended consequence which provides further support for the model.

This evaluation is limited due to the use of only one prison site, in one part of England and Wales (London), which limits the potential for these findings to be generalised. The work done is not experimental in nature for three main reasons: firstly because the resources needed to undertake such research were not available; secondly, because this service was rapidly developing and therefore subject to change (in fact, the very change that this study sought to evaluate); and thirdly, because the service operated an imperative, which was to provide clinical services for prisoners with mental illness. While multi-site experimental design is arguably the optimal choice for the examination of service-based approaches in health, it is also the case that any such design would have had its own limitations within a developing system whose prime function is the care and treatment of referred patients.

Despite the above limitations, this evaluation offers some evidence that the introduction of open referral systems within prisons, and their incorporation across offender health pathways, can lead to higher referral numbers, and thereby improved recognition of mental disorder. As such, they have the

potential to bolster the reception screening inefficiencies which have been identified internationally. In a wider sense, this work also raises serious questions about the liaison and diversion services which are currently being piloted across England and Wales with a view to their mainstream introduction, following new investment in pilot schemes (NHS, 2015).

The local referral effects shown in this evaluation now require further examination across a range of services, so that their implications for mental health services in prisons and the community can be better understood. It is likely that these liaison and diversion services will identify many more people for referral than before, on a national level, in which case it will be necessary to ensure that the services put in place to meet this demand are sufficiently resourced.

6.8. Acknowledgments

This evaluation was provider-led and NHS-funded.

6.9. Disclosure Statement

No potential conflict of interest was reported by the authors.

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Chapter 7. Referral and engagement outcomes after clinical contact with a police custody mental health liaison and diversion service

7.1. Citation

Forrester, A., Samele, C., Hallawell, C., Craig, T., & Valmaggia, L. (in submission). Referral and engagement outcomes after clinical contact with a police custody mental health liaison and diversion service.

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7.3. Acknowledgements

This evaluation was funded by Guy's and St Thomas' Charity. We are grateful for their support without which the clinical service could not have been developed. We also thank the organisational partners and team members who helped in the design and delivery of this service, and who enabled its evaluation.

7.4. Abstract

Title

Referral and engagement outcomes after clinical contact with a police custody mental health liaison and diversion service.

Background

Liaison and diversion services have developed in some jurisdictions, in part to respond to high levels of morbidity within criminal justice systems. Although there is evidence that these services are beneficial, the literature regarding their longer-term outcomes is limited. This project examined the referral outcomes from one such service operating in police custody.

Methods and Findings

Demographic, clinical, referral and health engagement outcome information was collected from consecutive assessments over a 9-month period (n = 516). The majority required onward referral (71.7%). Having existing service links in primary or secondary care was protective for future health engagement, but being male and actively using substances made engagement less likely.

Conclusions

This evaluation will assist onward service design in this area. Health service linkage should be prioritised as early in the process as possible, and critical time intervention models should now be piloted amongst this group. There is a probable role for brief substance misuse interventions in police custody.

7.5. Introduction

For very many years, we have been aware that people in the criminal justice system present with high levels of clinical morbidity, and that this morbidity is often complex and multiple in its nature (Smith, 1984). The literature in this field has been most clearly developed in prison settings, with studies across the world having consistently described increased mental health morbidity amongst people who are detained in them (e.g. Fazel & Seewald, 2012; Herman, McGorry, Mills & Singh, 1991; James, Gregory, Jones & Rundell, 1980). In addition to this psychiatric morbidity, many people in prison present with dual diagnoses, having co-morbid mental health and substance misuse disorders (Indig, Gear & Wilhelm, 2016; Singleton, Gatward & Meltzer, 1998). However, the literature goes further and also describes physical health morbidities, these having similarly been identified amongst this population over a number of decades (e.g. Novick, Penna, Schwartz, Remmlinger & Loewenstein, 1977). This description of the co-existence of multiple clinical problems amongst people in prisons is, however, far from a new phenomenon, having been identified and chronicled for over two Centuries (Howard, 1784).

In response to these high morbidity levels, the principle of equivalent care has been applied internationally since the early 1980s, when it was passed in a UN General Assembly resolution (Till, Forrester & Exworthy, 2014). In accordance with this resolution, nation States are meant to provide healthcare services of the *"same quality and standard as is afforded to those who are not imprisoned or detained"* (United Nations, 1982). Yet although the literature in this area has been both consistent over time and methodologically convincing, and despite these international attempts to drive improvements in health care

service delivery, reversing the burden of health morbidities experienced by people in prison has yet to properly commence. Instead, as the prison population has risen substantially across the world in recent years (Walmsley, 2015), attention in some States has increasingly turned to the idea that mentally disordered and vulnerable offenders should be diverted away from prison custody before they are received there. These earlier stages of the criminal justice system include police custody, where people are taken following arrest, and the lower (Magistrates') courts, where people first face criminal charges that have been brought against them. Unsurprisingly, in both of these areas high levels of clinical morbidity have also been identified through prevalence examinations, in keeping with the similar findings amongst people in prisons (e.g. McKinnon & Grubin, 2012; Shaw, Creed, Price, Huxley & Tomenson, 1999).

In England and Wales, one response to these high morbidity levels has been an increased national focus regarding the development of liaison and diversion services. These services have been in the policy spotlight since the publication of a government report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (Bradley, 2009). This report highlighted serious problems with existing services and recommended widespread and systemic change, including the development and standardisation of healthcare services operating across parts of the criminal justice pathway. In the five years following this report, a range of national stakeholders came together to produce an agreed operating model and associated working definitions (NHS England, 2014), as follows:

"Liaison and diversion is a process whereby people of all ages in contact with the youth and criminal justice systems are screened and where appropriate assessed or referred for assessment, so that those with mental health problems, learning disabilities, cognitive disorders, substance misuse problems and other vulnerabilities are identified as soon as possible in the justice pathway".

The underlying principle is therefore one of identification of clinical conditions, and vulnerabilities, as early in the criminal justice pathway as possible in order to enable health service access. Following identification, the liaison component of this model then involves onward referral to *"appropriate services including, but not limited to, mental and physical healthcare, social care, substance misuse treatment and safeguarding"*. The diversion component of the model, by comparison, is meant to be *"interpreted in its wider sense, referring to both diversion out of, and within, the justice system".* As a service-based and clinical response to high levels of morbidity, diversion has a strong history in the UK. It is an activity that can, at least in theory, take place at various stages across the criminal justice pathway (including police custody, the lower Magistrates' courts, or after being received into prison custody) (James, 2005). Yet although services offering this model have been supported by government since the 1980s, they have historically sat outside of the funding mainstream and their early development was therefore fragmentary (James, 1999). Early schemes were largely based in the lower courts (e.g. Exworthy & Parrott, 1997; Greenhalgh, Wylie, Rix & Tamlyn, 1996), and although there

were also some schemes operating in police custody, they mainly offered only liaison with other services (Laing, 1995; Etherington, 1996).

As these services have developed further, their benefits have increasingly become apparent through a series of evaluations across sites, models and countries (Scott, McGilloway, Dempster, Browne & Donnelly, 2013). Although there are, as yet, serious limitations to any experimental work demonstrating their wider effectiveness as regards service outcomes (Srivastava, Forrester, Davies & Nadkarni, 2013), the area of clinical identification is one in which there has been considerable progress in recent years. Screening tools can improve the detection of clinical issues across a range of conditions, and the evidence for their widespread implementation is now compelling (Noga, Walsh, Shaw & Senior, 2015; McKinnon, Srivastava, Kaler & Grubin, 2013; McKinnon & Grubin, 2010). Although there is good evidence that these services can enable immediate health service access through diversion (James, 2010), they may not be able to ensure improvements in wider service engagement at later stages (Broner, Lattimore, Cowell & Schlenger, 2004). However, for those who are linked in with services on an ongoing basis, there is some evidence that mental health improvements do take place (McGilloway & Donnelly, 2009).

Although the literature in this area has developed over the last 30 years, it still contains many gaps. This evaluation of health engagement outcomes from one police liaison and diversion service took place within that wider context, and it sits within a site evaluation framework that is presented elsewhere (Forrester, Samele, Slade, Craig & Valmaggia, 2016; Forrester, Samele, Slade, Craig & Valmaggia, in press). Its aim was to examine the health

engagement outcomes of a cohort of detainees who had been assessed by the mental health service operating in police custody, and to make onward service design recommendations.

7.6. Method

Sample

A total sample of 516 cases was collected, including 411 (79.5%) men and 102 (19.8%) women, ranging in age from 18 to 72.3 years (M = 36.5; SD = 10.8) (gender and age information was missing for three cases). The sample was collected over a 9-month period during 2012, and it included a series of consecutive mental health referrals that had been collected from the outset of the service. It is a sub-sample of a wider group of 1092 referrals whose demographic and clinical characteristics have been presented elsewhere (Forrester et al., in press).

Setting

The mental health service involved in this evaluation provided services to two police stations operating in one of the 32 boroughs in London. The service was facilitated by grant funding from Guy's and St Thomas' Charity and it was designed by a multi-agency group that included representatives of the Local Authority, the Metropolitan Police Service, and the local National Health Service mental health provider.

Service operating model

The service was delivered by Community Psychiatric Nurses (CPNs) who were based in the police stations for 12-hours per day, between 0800 and 2000 hours, although telephone support was also available from a Forensic Psychiatrist if it was required. The team utilised an open referral system

(Samele, Forrester, Urquia & Hopkin, 2016; Hopkin, Samele, Singh, Craig, Valmaggia & Forrester, 2016), meaning that referrals were accepted from all possible sources, and ensuring that no referral was declined by the team. After referrals were received, they were prioritised in terms of their clinical urgency before a face-to-face assessment was offered. The team attempted to see all referrals within four hours, this being the target that had been agreed by the multi-agency group in order to ensure that police detention requirements were appropriately met.

Procedure

Referrals were assessed in a private space in the police stations. The assessing CPNs had access to prior clinical records within the local mental health trust database if the person was already known to services. Initial assessments were undertaken using an agreed template that had been designed by the multi-agency group. This template was designed to ensure the production of a high quality standardised clinical assessment, and it collected detailed information across a number of categories (including: personal details, referral and response times; arrest information; clinical information; personal background information; risk information). It also included boxes for free writing to enable assessing clinicians to document their findings on mental state examination and to record their overall clinical impression.

After the assessment had been completed, the team then undertook its key functions of liaison and, or, diversion. The liaison function included discussion and information transfer between agencies across a range of sectors, including health, justice, social care and the voluntary sector. The diversion function, by comparison, involved referral or sign-posting to a range of

other agencies across these same sectors. The next phase of team liaison took place after the assessed individual had left police custody, and it involved making further contact with services to whom the person had been referred at a number of agreed stages: week 2; week 4; month 3 and month 6. This onward service liaison was part of the normal operations of the service, and at each point the liaising CPN recorded whether the person had engaged with the service to which they had been referred, or whether they had not.

Analysis

Service data were collected as a routine part of the service operations using the template described above. They were then transferred to an anonymised database at the end of each week, and the final complete database was analysed using a software package for statistical analysis (SPSS v 22). Descriptive statistics were generated, and once a final list of variables had been identified for each time point through preliminary models, a logistic regression model was created that included multiple predictors for each time point. Only variables that had enough data in each response option were included in the models.

Ethical considerations

The mental health service was designed and overseen by a multi-agency group that had come together to obtain grant funding to enable its implementation. All data were collected as part of the operational activities of the service and service evaluation approval was obtained.

7.7. Results

Demographic and clinical information

Demographic and clinical descriptors for the sample are included in Table 1. Most were registered with primary care services (84.3%) in the community, were single (66.7%) and were not working (82.1%). The majority were already known to mental health services (67.1%) or under the care of a community mental health team (56.6%) and were prescribed medication (55.7%). Almost four fifths (78.3%) reported current use of alcohol or drugs, with most (56.8%) having used substances in the immediate period (24-hours) before they were arrested (56.8%). Of some concern, almost a tenth of the sample presented with evidence of alcohol or drug withdrawal (9.4%) and over a fifth (20.8%) were clinically assessed as presenting a risk of suicide.

Table 1.

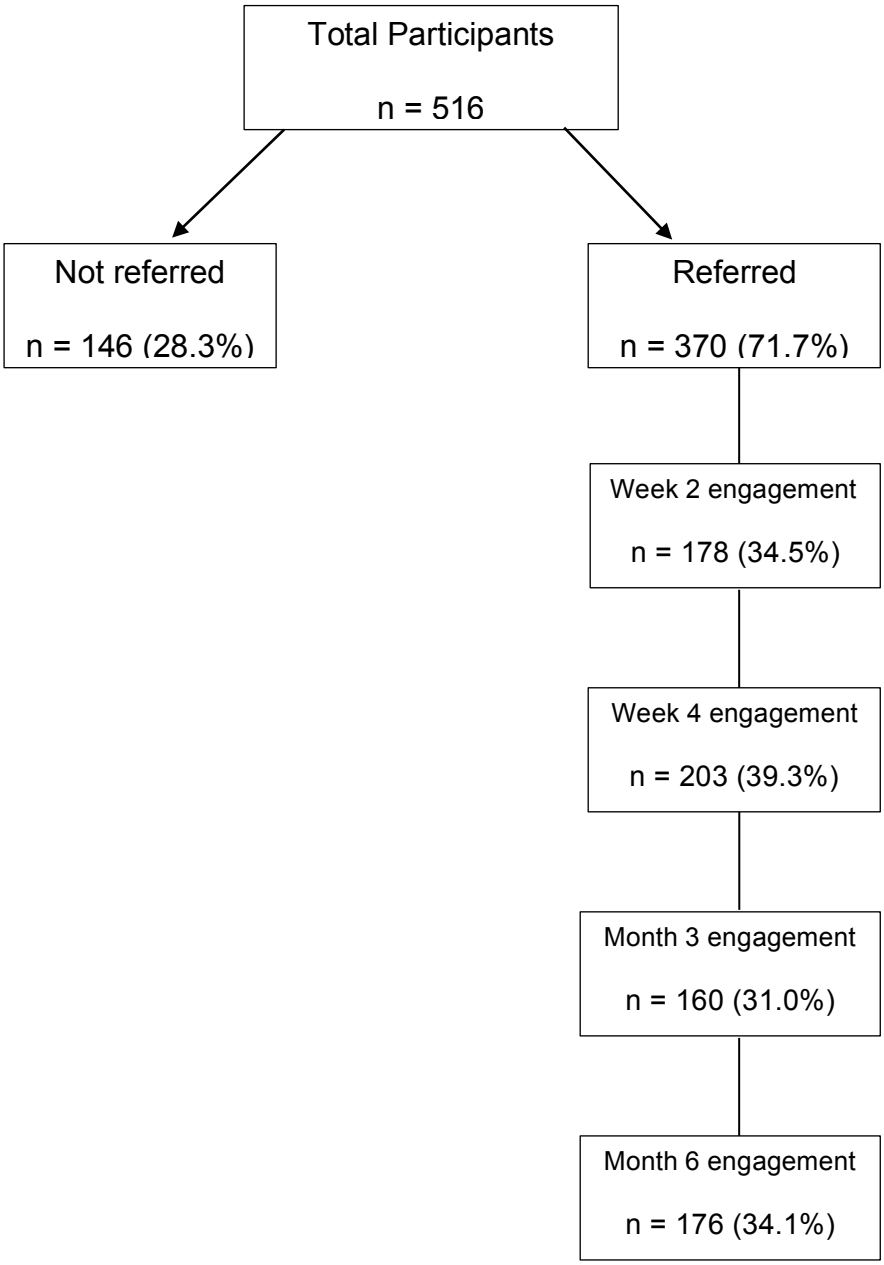
Frequency and percentage of demographic and clinical features

Demographics		N (%)
Gender	Female	102 (19.9%)
	Male	411 (80.1)
Ethnicity	White (British/Irish/Other)	240 (46.5%)
	Black (Caribbean/African/Other)	184 (35.7%)
	Asian (Indian/Pakistani/Bangladeshi/Other)	23 (4.5%)
	Mixed background	61 (11.9%)
	Any other ethnic background	8 (1.6%)
Registered with GP		398 (84.3%)
English as a first language		416 (80.6%)
Marital status	Single	344 (66.7%)
	Cohabiting	30 (5.8%)
	Married/civil partnership	30 (5.8%)
	Divorced/partnership dissolved	14 (2.7%)
	Not disclosed	51 (9.9%)
	Not known	31 (6.0%)
	Separated	14 (2.7%)
	Widowed/survived partner	2 (.4%)
Current housing arrangements	Homeowner	9 (1.9%)
	Social rented	202 (43.3%)
	Staying with family/friends	58 (12.4%)
	Hostel	65 (13.9%)
	Squatting	3 (.6%)
	Street homeless	33 (7.1%)
	Declined to say	93 (20.0%)
In employment currently		78 (17.9%)
Receiving benefits		257 (68.9%)
Highest educational qualifications	Degree or above	35 (6.8%)
	A-level or equivalent	34 (6.6%)
	GCSE or equivalent	89 (17.2%)
	Below GCSE level	48 (9.3%)
	Other qualification	15 (2.9%)
	No qualifications	117 (22.7%)
	Refused to say	111 (21.5%)
	Not known	67 (13.0%)
Clinical Features		
Consented to be interviewed		399 (77.5%)
Level of consciousness	Clear consciousness	456 (89.1%)
	Drowsy	50 (9.8%)
	Reduced consciousness	6 (1.2%)
Known to mental health services		336 (67.1%)
Known to Community Mental Health Team (CMHT)		196 (56.6%)
Prescribed medication		250 (55.7%)
Taking medication as prescribed		184 (76.7%)
Previously admitted to inpatient mental health services		216 (63.9%)
Current use of alcohol or drugs		328 (78.3%)
Used substances in 24-hours before arrest		222 (56.8%)
Evidence of alcohol or drug withdrawal		48 (9.4%)
History of self harm		170 (40.2%)
History of suicide attempts		171 (42.2%)
Suicidal ideas reported		73 (16.6%)
Assessed as presenting a current suicide risk		89 (20.8%)
Self harm has already occurred		35 (7.9%)

Referral information

From the referred sample of 516 participants, 370 were referred onto other services and 146 were not referred. Further engagement at each of the follow-up stages (week 2; week 4; month 3; month 6) is summarised in the flow-chart provided at Figure 1.

Figure 1. Referral Flowchart



After detainees were assessed by the mental health service, referrals were made to a range of services. Most referrals were made to community mental health teams (including prison mental health in-reach teams) or primary care services based in General Practice. The details of referrals made are outlined further in Table 2.

Table 2.

Frequency and percentage of mental health team service referrals

	Frequency	Percent
None	146	28.3
Other	12	2.3
Community mental health team (including prison in-reach team)	195	37.8
Drug/Alcohol service	30	5.8
Primary care (General Practitioner)	75	14.5
Mental health team AND drug/alcohol service	6	1.2
Social services	6	1.2
Court diversion	6	1.2
Approved mental health professional*	31	6
Voluntary sector	9	1.7
Total	516	100

*Approved mental health professionals work alongside medical practitioners to assess people who may require detention under the terms of the Mental Health Act 1983

Health engagement outcomes

Multivariate logistic regression results are presented in table 3 as odds ratios for health engagement predictors at weeks two and four, months three and six, and for any service take-up across the whole period.

Across the six month follow up period. Of those who were referred, any service take-up over the whole period of liaison follow-up was most likely amongst the following groups: people who had initially consented to be interviewed; who had a diagnosis of intellectual disability; who were registered with a General Practitioner in primary care; who were already under the care of a community mental health team; or who were registered on the local Mental Health Trust database. People least likely to take-up services over the whole period included those who had been found fit to be interviewed in police custody, and men.

At week two. At this earliest follow-up stage, three main variables predicted health engagement. These were having a diagnosis of intellectual disability, being registered with a General Practitioner in primary care, and already being under the care of a community mental health team. Men, people using alcohol or drugs, and people who reported having English as a first language, were less likely to engage at this point.

At week 4. At this stage, only one variable – being under the care of a community mental health team – predicted health service engagement. A number of other variables made engagement less likely, including: being in regular employment, being male, having English as a first language and having a history of suicide attempts.

At month 3. At this stage, only one variable – having a history of self harm – predicted service engagement.

At month 6. At this stage, only one variable – using alcohol or drugs – made health service engagement less likely.

Table 3.

Multivariate logistic regression for health engagement at a series of service liaison points

	Variables	Week 2	Week 4	Month 3	Month 6	Any Take-Up
Process variables	Location	-	-	-	-	-
	Primary care assessment	-	-	-	-	-
	Substance misuse review	-	-	-	-	-
	Medical review	-	-	-	-	-
	Found fit to be interviewed	-	-	-	-	0.485
	Having a criminal record	-	-	-	-	-
	Having a history of violent convictions	-	-	-	-	-
	On Bail	-	-	-	-	-
	Providing consent to be interviewed	-	-	-	-	3.092
Demographic variables		-	-	-	-	-
	Diagnosis intellectual disability	3.221	-	-	-	2.88
	Has Children	-	-	-	-	-
	Registered with primary care (GP) services	3.106	-	-	-	4.62
	English as a first language	0.218	0.341	-	-	-
	In work	-	0.296	-	-	-
	Male gender	0.236	0.297	-	-	0.353
Clinical and service variables						
	Known to a community mental health team	2.769	2.494	-	-	2.815
	Taking medication as prescribed	-	-	-	-	-
	History of inpatient admission	-	-	-	-	-
	Registered on local Mental Health Trust database	-	-	-	-	4.395
	Current use of alcohol or drugs	0.306	-	-	0.273	-
	Use of alcohol or drugs in the last 24-hours	-	-	-	-	-
	History of self-harm	-	-	-	-	-
	History of suicide attempts	-	0.448	-	-	-
	Current suicide risk	-	-	-	-	-
	Harmed self	-	-	5.336	-	-
	Has a mental health diagnosis	-	-	-	-	-

7.8. Discussion

This evaluation adds to the existing literature by being the first to examine health engagement outcomes following assessment and referral by a mental health service operating in police custody. In recent years, literature regarding the health morbidities experienced by people who are detained in police custody has developed, and as a consequence our understanding of the high levels of morbidity across clinical domains has improved (Forrester et al., in press; Senior et al., 2014). This improved understanding has led to calls for improved screening arrangements (Baksheev, Thomas & Ogloff, 2010), and more research to assist in determining the longer term effects of mental health service provision in police stations (Srivastava et al., 2013). In England and Wales, a recent national evaluation across ten pilot liaison and diversion sites attempted to address some of these longer term effects, but its limitations were such that they remained unclear. Nonetheless, the project did demonstrate increased identification of mental disorder and improved partnership working (Disley, Taylor, Kruithof, Winpenny, Liddle, Sutherland, Lilford, Wright & McAteer, 2016). An earlier evaluation across two pilot sites in England reported that 55 from an initial group of 547 people received community orders with mental health treatment requirements, with nine subsequently breaching these orders. Wider health engagement, however, was not examined (Winstone & Pakes, 2010). Elsewhere, there have been reports of high levels of hospital diversion following assessment (James, 2000), improved service access following review (Broner et al., 2004) and some mental health improvements at follow up (McGilloway & Donnelly, 2009). A more recent prospectively designed study used a comparison group, but demonstrated no change in mental health

symptoms between the intervention group and the comparison group over time (Scott, McGilloway & Donnelly, 2016).

The demographic and clinical features of the assessed group show similar findings to earlier literature (Forrester et al., in press), with most being men (80.1%), single (66.7%) and unemployed (82.1%). The group is ethnically diverse, with high reported levels of General Practice registration (84.3%), but high levels of street homelessness (7.1%). There are high levels of mental health service use, with many being known to mental health services (67.1%), this figure being higher than the 55% reported elsewhere (Ogloff, Warren, Tye, Blaher & Thomas, 2010). There are also very high reported levels of current alcohol and drug use (78.3%), histories of self harm (40.2%) and assessed suicide risk (20.8%), these figures also being higher than have been elsewhere (Payne-James, Green, Green, McLachlan, Munro & Moore, 2010). Overall, the described clinical features confirm that the high levels of morbidity and clinical risk, including risk from drug and alcohol withdrawal, that are reported throughout the literature in this area also apply within this sample (Forrester et al., in press).

The majority of those who were assessed (71.7%) required onward referral or signposting to a range of services, with most being referred to community mental health teams, including prison mental health in-reach teams (37.8%) or primary care services (14.5%). It is not possible to compare these figures within the wider literature because similar results are not available elsewhere. Nonetheless, the high level of referrals to mental health services reflects the underlying assessed morbidity of the group, and the need for referrals to a wide range of service types appears to confirm the underlying

multiple and complex needs of the group. Smaller numbers were referred to drug and alcohol services, suggesting that while the majority presented with current alcohol and substance use, dual diagnoses was also an issue for many. The 6% that required assessment under the Mental Health Act is less than the 31.4% found in an earlier London police liaison and diversion service (James, 2010), and this may reflect the widening of the scope of assessments through the use of an open referral system.

Across the follow up period, a number of demographic and clinical variables are predictive of engagement at different stages. The protective effect of service linkage is apparent here amongst those who are already registered and engaged with primary care or mental health services, or who have a diagnosis of intellectual disability. These factors are all predictive of onward health service engagement, and they emerge as an important target for future work. Further improvements could arise if liaison and diversion services were able to fast-track service registration processes, perhaps through direct links to specific practices and teams, or through link workers bringing additional support for a critical period. There are similarities here with intervention work done with released prisoners with mental illness, and this evidence indicates that piloting a similar critical time intervention model amongst this liaison and diversion group would now be useful (Jarrett, Thornicroft, Forrester, Harty, Senior, King, Huckle, Parrott, Dunn & Shaw, 2012).

Meanwhile, some other variables make non-engagement more likely across a range of stages, including being male, reporting current use of alcohol and drugs, having English as a first language and being in work. These findings are important because they indicate a need for services to target these groups.

Substance misuse services, however, often have high non-attendance rates that are associated with poorer longer-term outcomes (Milward, Lynskey & Strang, 2014). Brief interventions, however, have a growing evidence base (Newbury-Birch, McGovern, Birch, O'Neill, Kaner, Sondhi & Lynch, 2016) and they are feasible in police custody (Chariot, Lepresle, Lefevre, Bourad, Barthes & Tedlaouti, 2014). The argument that they should therefore be applied routinely in these settings is mounting.

This evaluation has a number of limitations that should be acknowledged. It examined the outcomes of a real clinical service and it was not experimentally designed because its priority was the management of people who were assessed by it. Although the work took place in two police stations, they were in the same geographical area, so it was not multi-site in nature. There are therefore limitations to its application in other areas. The collected information did not include criminal justice system outcomes because this was beyond both the remit and the resources of this evaluation, but it will be important for such outcomes to be considered in future work.

7.9. References

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Chapter 8. Conclusions and general discussion

8.1. Project aims

This chapter considers the main conclusions of the work, measured against the original key aims of the overall project. These aims, outlined earlier in chapter one, were as outlined in Table 1 below:

Table 1.

Overview of project aims

First aim	To describe the demographic and clinical characteristics of a cohort of consecutive referrals to a mental health service that was introduced as a grant-funded pilot to two police stations in one London borough (in Brixton and Kennington) over an 18-month period.
Second aim	To examine the prevalence of suicide ideation amongst this same cohort.
Third aim	To evaluate the potential effects of this new service, and the introduction of an open referral system, upon mental health work undertaken elsewhere in the local pathway, at Brixton Prison.
Fourth aim	To examine the health engagement outcomes of a sub-group of consecutive referrals to the service, over a 9-month period.
Fifth aim	To consider onward recommendations for research and service delivery in this field.

8.2. The first aim: demographic and clinical characteristics

This first aim was met successfully, and the demographic and clinical characteristics of the first consecutive 1092 referrals to the service over an 18-month period are described in chapter 3. The key conclusions of this work are as follows:

- As regards demographics, the sample included mainly men (79.6%), but also a larger number of women than expected (20.4%). It was mixed, with a range of ethnicities represented, the majority being single and unemployed, and many describing unstable accommodation arrangements.
- Most were already known to primary care or mental health services, being registered with a GP and actively under the care of a mental health team. Overall, there were high reported levels of mental health and substance misuse disorders, and concerning levels of intoxication and alcohol/substance withdrawal and suicide risk.
- Although the literature in this area is presently limited, these findings are broadly in keeping with it. In some areas, the morbidity described appears to be higher than has been found by other groups, although this service did assess a selected group of mental health referrals rather than considering all cases going through police custody.
- There were some important gender differences. Men were more likely to have a criminal record, prior convictions for violence, to report active alcohol or drug use, and to require diversion to hospital. Women were more likely to report histories of self-harm or suicide attempts, or to be assessed as presenting a suicide risk.

Overall, this work adds to the existing literature, which presently contains few descriptions of such services. It is the second mental health service operating in police custody to be described in the London area, following an earlier description of a central London scheme that mainly operated with a diversion focus (James, 2010). It is therefore the first fully operating police liaison and diversion service to be described in this way, and its findings are likely to be useful for onward service planning and design locally, and across the London region. It also adds to the existing prevalence literature (e.g. Dorn, Ceelen, Buster, Stirbu, Donker & Das, 2014; Clement, Gerardin, Victorri, Guigand, Wainstein & Jolliet, 2013; Baksheev, Thomas & Ogloff, 2012; McKinnon & Grubin, 2012) by confirming that the high levels of mental health and substance misuse disorders, and suicidality, that have been identified elsewhere are also present in a group of people who have been referred to mental health services within police custody. This project identified much higher levels of previous mental health service use than earlier prevalence work (64% vs 25%: Baksheev, Thomas & Ogloff, 2010). However the project considered a sub-sample of people who were referred to mental health services, rather than reviewing all arrests, and this could explain the difference. In keeping with other literature (e.g. McKinnon & Grubin, 2012), this evaluation highlights serious clinical safety issues in police custody, with important numbers presenting with reduced consciousness, substance intoxication, frank withdrawal from drugs or alcohol, self harming behaviour and risk of suicide. Although these findings are consistent with earlier literature, they do signify a requirement for robust and integrated clinical services that have appropriate access to specialist facilities when they are required.

8.3. The second aim: suicide ideation

This second aim was also successfully met and the key conclusions arising from it are as follows:

- The suicide prevalence amongst the assessed group was 16.2% overall. Women were more likely to report suicide ideation than men, and most of those reporting suicide ideation had a prior history of self-harm or a previous suicide attempt.
- People in some diagnostic categories were at higher risk of suicide ideation, and these diagnostic categories included: depression; post-traumatic stress disorder; and personality disorder.
- Those who exhibited suicide ideation were more likely to have a history of mental health service contact, or to have used alcohol or drugs within the 24-hour period before their arrest.

Although these findings are also consistent with the wider literature (e.g. McKinnon, Srivastata, Kaler & Grubin, 2013; Scott, McGilloway & Donnelly, 2009), this particular area is one in which there have only been a small number of studies. This project adds to this existing literature by presenting suicide ideation findings amongst a sub-group of arrestees who were referred to mental health services. The finding that 16.2% of people assessed presented with active and current suicide ideation does, however, in itself make a case for appropriate service delivery in order to meet this presenting need.

8.4. The third aim: evaluating the effects of an open referral system

This aim was partially met. Although the evaluation was successfully able to identify the effects of an open referral system on the work-load in another part of the criminal justice pathway, it was not able to examine the direct effects

of this new service on that referral pattern. This is because the function of the local prison changed from a category B remand prison to that of a category C resettlement prison shortly after the criminal justice mental health service became operational. Nonetheless, the evaluation was able to assess the effects of the introduction of an open referral pathway, and found the following:

- After the introduction of an open referral system, the number of team referrals doubled (across two assessed periods in 2008 and 2011).
- There were improvements in the identification of people who had no previous mental health problems.

At present, there is no other literature examining the effects of an open referral system within mental health services operating in criminal justice systems. Nonetheless, as a service initiative its use has become fairly widespread within prison mental health teams and liaison and diversion services. Literature from other areas has, however, demonstrated improved practitioner satisfaction after such systems have been introduced (Puri, Hall, Reefat, Mayer & Tyrer, 1996), and increased sensitivity to need when compared with closed referral systems (Marriott, Malone, Onyett & Tyrer, 1993). From the perspective of illness identification, this initiative had positive effects, with significant improvements in the identification of people who had no prior contact with services. However, from a service management perspective, it resulted in a doubling of the local referral rate, increasing the workload of the mental health team while bringing no extra resources to manage the consequences. Although the effects of the criminal justice mental health service were not fully assessed by this evaluation, it is reasonable to think that the further adoption of an open referral system within police custody, operating

across the entire criminal justice pathway, would result in a further increase in referral numbers. This therefore has potential implications for resource allocation not only locally or within the London area, but nationally.

8.5. The fourth aim: to examine health engagement outcomes

Although there were limitations to this work, it was able to describe referrals that had been made by the team following initial assessment amongst a consecutively referred sample of 516 people. The key conclusions were as follows:

- Most of those who were assessed by the team required onward referral (71.7%) to a range of services within health and other sectors.
- Having existing links with primary care and mental health services was broadly predictive of future service engagement.
- Being male and reporting active current substance use meant that future service engagement was less likely.

Although some earlier evaluation work has attempted to describe outcomes from liaison and diversion services, this area is not one in which there has been much success within the literature to date (e.g. Disley, Taylor, Kruithof, Winpenny, Liddle, Sutherland, Lilford, Wright and McAteer, 2016). This project therefore adds to existing knowledge by describing the number and range of referrals made by a police liaison and diversion service for the first time, and by reviewing health service uptake at a range of subsequent stages. The health engagement associations described in chapter 7 have not previously been examined in the literature, to which this work is an addition.

8.6. The fifth aim: research and service delivery recommendations

Service delivery recommendations.

Some key service delivery recommendations have arisen throughout the project, and they are as follows:

- It is possible to apply a mental health service in police custody, and this particular service was able to provide assessments to people who would otherwise not have received specialist mental health review had the service not been in place. Wider application of this service model is recommended, and these findings offer support for the 24-hour 7-day national operating model that is now being proposed.
- Given the literature in this area, and the findings of this evaluation, health services operating in police custody can expect to encounter high levels of mental health and substance misuse disorders, and high levels of physical health problems. Complex clinical conditions, clinical risk and diagnostic co-morbidities are prevalent. Therefore, it is important to ensure that services are appropriately planned and designed, and that they are adequately resourced to meet the presenting health needs.
- The reported levels of suicide ideation and assessed suicide risk are concerning. Given improvements in our understanding of the link between suicide ideation and completed suicide arising from the wider literature, these findings support calls for a standardised risk-based health screening process that targets groups at higher risk, including women.
- The findings also support calls for improved safety arrangements for people who have used alcohol or drugs in the period before their arrest.

- The introduction of an open referral system can lead to a considerable increase in the overall number of team referrals, resulting in an increased workload. It can, however, also assist in identifying more people who have no prior history of mental health problems, and it may be one way to improve the identification of people who have been missed by earlier screening processes.
- In order to ensure optimal health engagement, service linkage should be prioritised as early as possible given the protective nature of current service registration. This could potentially be facilitated by a number of service innovations, although further research would be useful in order to demonstrate their effectiveness first. One such service innovation could involve the use of a critical time intervention, this model having been successfully applied to prisoners with mental illness upon their release from custody. Another could involve developing links with specific practices and teams, to which people who are not already registered with services could be fast-tracked.

Research recommendations.

The field of liaison and diversion services is one in which although there have been many useful evaluations published, the introduction of experimental work in this area has been limited. There is now a need for more experimental work, including randomised controlled trials, to assist in determining which aspects of service provision and delivery work best, and how investment should be targeted. Therefore, there is a clear role for research funding bodies to play in prioritising both service-based, and disease-based, research in this area. The following research recommendations arise specifically from this project:

- The advantages of health screening in police custody settings have been established in the literature. However, it has not yet been possible to implement screening nationally because of the way the Police Service is organised in England and Wales, and because of its existing information technology arrangements (Slade, Samele, Valmaggia & Forrester, in press). There is therefore now a need for implementation science to consider methods to promote uptake of the research findings into clinical practice. This could, for example, involve a number of pilots within specific police forces, with a focus on the delivery of existing screening research findings.
- Given concerning levels of suicide ideation and clinically assessed suicide risk, it would be useful to pilot new methods for observation and engagement in police custody, with the aim of improving safety arrangements. In designing these pilots, it would be helpful to look to the methods used in implementing the Assessment Care in Custody and Teamwork (ACCT) process throughout the Prison Service in England and Wales. This multi-agency approach to managing self harm and suicide risk had some success after it was implemented elsewhere (Slade & Forrester, 2015; Forrester & Slade, 2014; Ministry of Justice, 2013).
- Given the findings in respect of service non-engagement following assessment and referral, and the established wider literature which demonstrates excessive non-engagement amongst substance misusing groups, it would now be helpful to consider implementing brief interventions in police custody. Feasibility studies have already been

done, and many brief interventions are already available, so this is another area in which implementation is required. Pilots could now assist in determining what can work as regards application in police custody.

- It would also be useful to introduce pilots for service fast-track registration processes following assessment in police custody. This could, for example, involve the use of specific primary care settings (General Practice surgeries) and particular community mental health teams working closely alongside liaison and diversion services.
- Another approach to improving registration and follow up could involve the use of a critical time intervention, this approach having been successfully implemented amongst released prisoners with severe mental illness (Jarrett, Thornicroft, Forrester, Harty, Senior, King, Huckle, Parrott, Dunn & Shaw, 2012). It would now be useful to test such an approach, using experimental methods, amongst people who have been assessed by liaison and diversion services to examine whether it can lead to improved health engagement, and whether it has a wider effect on re-offending behaviour.

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Appendix 1. Mental Health in Custody Assessment Tool

Date of Assessment: Time of Assessment:
LOCATION:

1. Personal Details (Preparatory) – includes some Direct Personal Information	
Name: Date of Birth Address:	Alias Name +/- dob: Gender: M F Transgender Transsexual
2. Referral and Response Time:	
Custody Number: *Date/Time of Arrest:* *Date/Time of Ref to CJMHS:*	
Delays? Yes No	State reason for delay (intoxication, referred out of hours, etc)
3. Arrest Information	
Referred by? (Enter Number) **1.** No source/identified by CJMHS **2.** Police **3.** Custody Nurse/FME **4.** Substance Misuse Worker **5.** CMHT **6.** Voluntary sector **7.** Self/Family **8.** Solicitor **9.** Court Staff **10.** Judiciary/Magistrate **11.** Court/Cell Detention Staff **12.** Prison service **13.** Probation Service **14.** Other **99.** Unknown **Reason for Referral:**	
PNC Flashes/Warnings? (*Drugs, Mental Health, Weapons, Violence, Self harm*). Please state:	
Seen By: Arrest Referral Worker Yes No FME/Custody Nurse Yes No	*Has the initial police screen been done?* **Y N** *Has the DP been deemed fit for I/V?* **Y N**
What Offence has the DP been arrested for? See table below for examples. Enter offence number here: **Offence Description**:	
1. Breach of Peace/Public Order offence, Drunk/Disorder/Loitering, **2.** Poss. Class A (Amphetamines, cocaine, heroin), Poss. Class B (Cannabis), Cultivate/Supply, Import/Export Drugs **3.** Criminal damage **4.** Arson/Arson with Intent **5.** Theft and Handling, Going Equipped **6.** Burglary **7.** Robbery **8.** Fraud/Forgery, Deception **9.** ABH, Affray/Violent Disorder, GBH, Common Assault Armed Robbery Malicious Wounding, Offensive Weapon, Threats to Kill/Wound, Endangering Life, Cruelty/Neglect Child **10.** Murder, Manslaughter **11.** Rape, Indecent Assault, Indecent Assault Child, Other Sexual Offences, Exposure, Gross Indecency **12.** Offences relating to Police/Court/Prisons, Summary Offences **13.** Vehicle Crime **14.** Motor Offences **15.Other** e.g. Harassment **99**. Unknown	
Arrest Information (from Police Front Sheet).	For Violent Offences: Details of victim (please define victim below).E.g. – spouse/family, stranger, clinician, police, etc.
Does the DP have a Criminal Record? **Yes (1-2) Yes (3+) No** *Does the DP have convictions for violence* **Y N** *Was the DP on bail/arrested because of a warrant?* **Y N** Has the DP had previous spells in prison? **Y N**	

Unknown	

Criminal Record Summary (Take particular note of violent offences and note in risk to others during risk screen):

4. Consent

Have you discussed info sharing? **Y N**	*Any reservations?* **Y N** (state if Y)
Information leaflet offered **Y N**	*Consent obtained for IV?** **Y N**

If No, are you concerned enough to continue despite the DP's lack of consent? **Y N**

*If there is concern, please continue completing as much of the MHiC as possible.	If there are few concerns complete summary and produce output letter for Cust. Sgt. and complete checklist.

5. Consciousness

DP's level of consciousness?	Clear Drowsy* Reduced*
Is there any evidence of intoxication?	Yes* No
Is there evidence of current alcohol or drug withdrawal?	Yes* No

*Please expand if Yes selected above and consider terminating IV and referring to FME

6. Learning Disability

Has the DP ever been diagnosed with a Learning Disability?	1. Yes 2. No 3. Not known

Consider completing LDSQ at this stage using separate paperwork.

7. Direct Personal Information/Children Info (continued from Personal Details above)

GP details None Not known Refused	*GP Name/Address:* Tel:

Country of Birth:	English? Y N	Interpreter? Y N	If Y, Language

Ethnicity? ***Enter ethnicity code here***:

1. White British 2.White Irish 3.Any Other White background 4.Mixed White/Black Caribbean 5.Mixed White/Black African 6. Mixed White/Asian 7. Any Other Mixed background 8. Asian/British Indian 9. Asian/British Pakistani 10. Asian/British Bangladeshi 11. Any Other Asian background 12. Black/British Caribbean 13. Black/British African 14. Any Other Black background 15. Chinese 16. Any Other ethnic background

Armed Forces Personnel? *(Place 'X')*

Yes (continue below) No

Serving - 1. Male 2. Female 3. Intersex 4. Other 97. Prefer not to Say **Veteran** - 1. Male 2. Female 3. Intersex 4. Other 97. Prefer not to Say
Marital Status? Enter number here: 1. Single 2. Divorced 3. Married 4. Civil Partnership 5. Not disclosed 6. Not known 7. Separated 8. Widowed/survived partner
Enter spouse/carer/nearest relative details here, especially if a direct carer of any dependants: Name: Date of Birth/Age: Address/Location: Can this person be contacted if necessary? Yes No
Do you have children? Yes No Refused Not known
How many children? Record details below adding further Child details as necessary
Child 1 Name Child 1 dob (or approx age) Address of this child Living with DP **Y N** Child 2 Name Child 2 dob (or approx age) Address of this child Living with DP **Y N** Child 3 Name Child 3 dob (or approx age) Address of this child Living with DP **Y N** **Is the detainee a Looked After Child?** Yes No Unknown **If Yes, please copy name of Social Worker and responsible Local Authority below.**
Additional Children information. Use this free text box to clarify or confirm any additional information that may be useful, especially if there are Safeguarding Children concerns. Consider other direct carers of children and provide name, age/dob, location/postcode if possible. Please also complete Child Need Screen on ePJS.

Is the family ***currently*** known to Ch. and Fam. services? Yes No Not known Refused	***Previous*** contact with Ch. And Fam. services? Yes No Not known Refused
If Yes to above – state name of SW and/or Service, approx date of contact, or any other relevant information:	
Is there anyone else at home? Yes No Not known Refused	Record details of others at home address:

Registered Carer?
Do you consider yourself to be a Carer? **Yes No** If Yes, are you a registered carer? **Yes No n/a** Would you like some information concerning local Carers services? **Yes No n/a**

Accommodation Status (*Enter Number*): **1.** Mainstream Housing **2.** Homeless **3.** Accommodation with MH support **4.** Acute/Long-stay healthcare residential/hospital **5.** Accommodation with other care support **6.** Accommodation with criminal justice support **7.** Sheltered Housing **8.** Mobile Accommodation **9.** Other **10.** Not disclosed/known	
Employment Status (*Enter Number*): **1.** Paid **2.** Self employed **3.** Housewife/Husband/Carer **4.** Full time student **5.** Long term sickness/disability **6.** Retired **7.** Unemployed **8.** Other/Not disclosed **99.** Unknown	
Optional - Other Information around Social Circumstances (Housing, Employment/Study, Social Support – Family/Friends, Benefits/Finances/Debts, Leisure/Hobbies, Spiritual/Religious/Cultural, Psychosexual)	
9. Mental Health Information	
Do you take medication for your mental health?	Yes No Not known Refused
If Yes, enter medication details	
Have you been taking your meds as px?	Yes No Not known/applicable Refused
Are you known to MH services? (includes current and past contact)	Yes No Not known/applicable Refused
If Yes – state **diagnosis** (include info from ePJS)	
If previously known to MH services, when was last contact with services?	State:
If Yes – which are you known to?	SLaM Other NHS Trust Other Provider Record Other Trust/Provider (if known):
If Yes – Do you have a care co-ordinator, or are known to a Community Mental Health Service? Yes No Not known Refused to disclose	
Previous Contact with Liaison and Diversion Services? Yes No Not known Refused to disclose	
CC Name, Address of CMHT and Tel/Fax.	
Have you been admitted to inpatient mental health services?	
Yes Refused No Not known	If Yes – summarise details here (inc. number of admissions or last known admission, if known)
Is the DP reg. on ePJS? Yes No	
9. Substance Misuse Information	
Do you use alcohol or drugs? Yes No Not Known Refused	

Please Select: Drugs (Class A): *Cocaine* *Crack* *Heroin* Drugs (Class B, C): *Acid/LSD* *Amphetamines* *Cannabis* *Ecstasy* *Solvents* *Tranquilisers* Alcohol *Other – state*: **Briefly comment on drug use below (frequency/amount/type/smoked/injected/etc)**	
Drug Use:	
What is the nature of your alcohol use? *Include Type/Strength/Amount/Frequency/Pattern/Medical issues*	
Used alcohol/illicit substances in last 24 hours?	Yes No Unable to comment Refused
If yes: What taken? How long ago? How much?	
Are you known to Drug or Alcohol Services?	Yes No Not known Refused to Disclose
If Yes, write in name of key worker and service:	
10. Orientation	
Day of the week?	Today's Date?
Do you know where you are? Answer:	Are you aware of why you're here? Answer:
Consider capacity and cognitive issues that may affect interview, etc and record concerns after Mental State Examination.	
11. Mental State Examination	
Mental State Guide: **Appearance** *(attire, cleanliness, posture, gait)* **Behaviour** *(facial expression, aggression/arousal, agitation, rapport, co-operation)* **Speech** *(form and pattern, volume and rate, coherence, logical, coherent, congruent)* **Mood** *(apathetic, irritable, labile, optimistic or pessimistic, energy levels, motivation, anger, anxiety, thoughts of suicide, guilt, hope, self esteem, sleep, appetite, worthlessness,*	**Appearance, Behaviour, Speech**: **Mood**: **Perception**: **Thoughts**:

hedonia) **Perception** *(abnormalities including hallucination occurring in any modality – auditory, visual, smell, taste, touch)* **Thoughts** *(quantity, tempo, logical coherence, delusions, overvalued ideas, obsessions, phobias, preoccupations, thought disorder, thought interference – withdrawal, insertion, broadcast, ideas of reference, passivity.* **Cognition** *(brief note of cognitive and intellectual function; is the person orientated in time, place and person. Evidence of memory problems, attention span, reliable informant). Consider Capacity and record below*.* **Insight** *(how does the person explain or attribute his or her symptoms)*	**Cognition**: **Insight**:

***Consent and Capacity Information**

NB: A person over 18 is assumed to have capacity unless there is a permanent or temporary disturbance of behaviour/mind that may question capacity. This could be due to physical/mental health, learning disability, intoxication or other.

If there is a concern here, consider: can the person understand information, retain information, 'weigh up' the information about the decision and communicate their needs/wishes about the decision. If all criteria met, DP likely to have capacity.

Any Other Relevant Information (please record any other relevant clinical information here – this may include aspects of their personal history/psychiatric history/family mental health history, etc)

12. Brief Risk Screen (Record **factual** information here)

a. Does the person have a history of self	Yes	No	Not Known	Refused

harm?	
b. Does the DP have a history of suicide attempts?	Yes No Not Known Refused
c. Does the person report homicidal ideation?	Yes No Not Known Refused
d. Does the person report current suicidal ideas?	Yes No** Not known Refused
e. **If No, does the person pose a suicide risk?	Yes No Unable to specify
f. Has the person harmed themselves in custody?	Yes No Not known Refused
g. Has the person harmed themselves in the last 72 hours?	Yes No Not known Refused

If Yes to questions a. – g. please provide further information:*(include exploration of any recent attempt, including triggers, intentions around the act, details of planning vs. impulsiveness, feelings after the incident, actions taken after incident, etc)*

Brief Risk Screen (cont.) – Record **formulation** here.
Include protective factors/aggravating factors (e.g. alcohol/drugs, family support, religious beliefs, etc

Where there may be risk to others (Adult/Children) – consider discussing with the Officer in Charge (OIC) of the investigation to see whether MERLIN/Safeguarding referrals are necessary.
Select as many of the following risk categories as applicable:

Risk Guide: **To Self** *(suicide, deliberate self harm, accidental self harm, self neglect, addiction, recklessness)* **To Others** *(verbal/physical aggression, threats of violence, sexually inappropriate, children)* **Vulnerability** *(financial abuse, physical abuse, emotional abuse, sexual abuse, exploitation, soliciting)* **Environmental risk** *(fire, unsafe house, lack of amenities reported – e.g no cooker, no heating)* **Unstable mental state** *(mental health liable to deteriorate quickly or unpredictably, addiction*	**Risk to Self:** **Risk to Others:** **Vulnerability:** **Environmental Risks:** **Unstable Mental State:**

issues) **Compliance problems** *(with medication, with services)* **Risk to or from Others** *(consider Safeguarding Adult concerns, need for Merlin reporting)*	**Compliance Issues:** **Risk to, or from, others:** **Other Risks:**

13. Assessors Impression Please also state **time** that interview ended here:

Does the DP have an established or presumed mental disorder?	Yes No Not Known

If Yes: What is the identified Need? (Enter number):

1. None **2.** Schizophrenia/Delusional Disorder **3.** BPAD **4.** Depressive illness **5.** Anxiety/Phobia/OCD/PTSD/Panic **6.** Eating Disorder **7.** Dementia **8.** Attention Deficit Disorder **9.** Personality Disorder
10. Adjustment Disorder/Reaction **11.** Acquired brain injury **12.** Organic Disorder **13.** Learning Disability **14.** Alcohol **15.** Drugs – Class A **16**. Drugs – Class B/C **17.** Accommodation **18.** Financial **19.** Other **99.** Unknown

What is your Clinical Impression of the person's presentation?

*****The detained person has been apprised of the purpose of this assessment and **has/has not** agreed that information can be shared with other relevant agencies.

Consent Form signed? **Yes No**

Where the detained person has not consented to information being shared (or expressed reservations in part) and yet concerns exist – state whether information shared without consent and with whom, recording reasons for doing so here:

Output to copy to Custody Sergeant letter
Copy over Brief Risk screen into relevant section of the Custody Sgt template letter. Include details of children and indicate need for Merlin reporting (Children and Vulnerable Adults)
Output to copy to letter for FME (add below information to beginning to FME output letter)
Is there evidence of drowsiness or impaired consciousness? Yes No Is there evidence of substance withdrawal Yes No Do you have any immediate concerns about the detained persons physical health? Yes No Please briefly describe your concerns below.
Output to copy to Childrens and Family Letter (add below information to Childrens and Families letter below Childrens details)
Please expand on your concerns about a child/ren. Consider discussing case with a senior. Reason for Referral Perceived impact of the DP's mental health on the child/ren
Additional Information (include case outcome if known, time of referral to AMHP service, time other professionals attended (2 x Dr and AMHP), name of Officer in Charge, etc. Also include recommendations for CGMC to be used in GMC template letter.

Has the person signed a Consent Form re: Information Sharing

Complete Custody Checklist (next page)

Copy relevant information to Custody Templates (Custody Sgt, Adult with Learning Disabilities, Childrens and families, GP, CMHT, Camberwell Green magistrates Court.

Appendix 2. List of publications

Forrester, A., Samele, C., Slade, K., Craig, T., & Valmaggia, L. (in press). Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals. *The Journal of Forensic Psychiatry and Psychology.*

Forrester, A., Samele, C., Slade, K., Craig, T., & Valmaggia, L. (in press). Suicide ideation amongst people referred for mental health Assessment in police custody. *The Journal of Criminal Psychology.*

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